

L.E.
VS
LEE, et al.

MELISSA CYPERSKI, PH.D.

August 10, 2022



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1 IN THE UNITED STATES DISTRICT COURT
2 FOR THE MIDDLE DISTRICT OF TENNESSEE
3 NASHVILLE DIVISION

4 L.E., by his next friends and
5 parents, SHELLEY ESQUIVEL and
6 MARIO ESQUIVEL,

7 Plaintiff,

8 vs.

 No.: 3:21-cv-00835

9 BILL LEE, in his official
10 capacity as Governor of
11 Tennessee, et al.,

 Chief Judge Crenshaw

12 KNOX COUNTY BOARD OF
13 EDUCATION a/k/a KNOX COUNTY
14 SCHOOL DISTRICT; ROBERT M.
15 "BOB" THOMAS, in his official
16 capacity as Director of Knox
17 County Schools,

 Magistrate Judge
 Newbern

18 Defendants.

19 Videoconference Deposition of:

20 MELISSA A. CYPERSKI, Ph.D.

21 Taken on behalf of the Defendants
22 August 10, 2022

23 Commencing at 9:37 a.m.

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25 www.elitereportingservices.com
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2 S T I P U L A T I O N S
3

4 The videoconference deposition of
5 MELISSA A. CYPERSKI, Ph.D. was taken by counsel for
6 the Defendants, by Notice, with all participants
7 appearing at their respective locations, on
8 August 10, 2022, for all purposes under the
9 Tennessee Rules of Civil Procedure.

10 All objections, except as to the form of
11 the question, are reserved to the hearing, and said
12 deposition may be read and used in evidence in said
13 cause of action in any trial thereon or any
14 proceeding herein.

15 It is agreed that Deborah H. Honeycutt,
16 Notary Public and Licensed Court Reporter for the
17 State of Tennessee, may swear the witness remotely,
18 and that the reading and signing of the completed
19 deposition by the witness is not waived.
20
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25

* * *

THE REPORTER: Good morning. My name is Deborah Honeycutt. I am a stenographic reporter with Elite-Brentwood Reporting Services. My license number is 472.

Today's date is August 10, 2022, and the time is approximately 9:37 a.m. Central time.

This is the deposition of Melissa A. Cyperski, Ph.D. in the matter of L.E. by his next friends and parents, Shelley Esquivel and Mario Esquivel vs. Bill Lee, Governor of Tennessee, et al., filed in the United States District Court for the Middle District of Tennessee, Nashville Division. The Case Number is 3:21-cv-00835. This deposition is being taken by videoconference, and the oath will be administered remotely by me.

At this time, I'll ask counsel to identify yourselves and state whom you represent. If you have any objections with the procedures I've outlined, please state so when you introduce yourself. We will start with the noticing attorney.

MR. HILDABRAND: This is Clark
Hildabrand. I am representing the State Defendants
in this case, along with Travis Royer is here right

1 now, and Stephanie Bergmeyer will be joining later
2 in the deposition.

3 MS. BROWN: Again, Taylor Brown from the
4 American Civil Liberties Union for Plaintiff.

5 MS. BORELLI: This is Tara Borelli with
6 Lambda Legal for the plaintiff.

7 MS. BROWN: We also have with us Cameron
8 Vaughn for Plaintiff from the ACLU of Tennessee.
9 And then we also have -- Britany, do you want to
10 introduce yourself?

11 MS. RILEY-SWANBECK: Yes. This is
12 Britany Riley-Swanbeck from Wilmer Hale.

13 MR. SANDERS: And this is David Sanders
14 representing Knox County Board of Ed. and Dr. Jon
15 Rysewyk.

16
17 * * *

18 MELISSA A. CYPERSKI, Ph.D.,
19 was called as a witness, and after having been duly
20 sworn, testified as follows:

21
22 EXAMINATION

23 QUESTIONS BY MR. HILDABRAND:

24 Q. All right. Thank you for coming to testify
25 today. As we just said, my name is Clark

1 Hildabrand. I'm one of the attorneys for the State
2 of Tennessee. Just for the record, could you say
3 and spell your last name?

4 A. Good morning. My name is Melissa Cyperski.
5 C-Y-P-E-R-S-K-I.

6 Q. Thank you. Before we get underway, I just
7 want to lay out some ground rules. If I cut you off
8 too early, just let me know and I'll let you finish
9 your answer. Similarly, just try to let me finish
10 my answer as well -- sorry -- finish my question as
11 well before you answer. The attorneys there would
12 also appreciate if you give them a second to give
13 them a chance to object if they need to. But unless
14 they instruct you not to answer because of
15 attorney-client privilege, after they object you
16 should answer the question. Is that good with you?

17 A. Yes.

18 Q. And since we're trying to create a clear
19 transcript, I'd appreciate it if you could answer
20 with a clear verbal response rather than just
21 shaking your head yes or no like we do in a
22 conversation if we were just having conversation
23 back and forth. Does that make sense?

24 A. Yes.

25 Q. And unless you tell me you don't understand

1 the question, is it fair to assume you understood
2 the question and answered to the best of your
3 ability?

4 A. Yes.

5 Q. If you need to take a break at any point, let
6 us know. We'll try to take breaks every once in a
7 while, maybe once an hour, and also break for lunch
8 at some point.

9 And just to establish the validity of the
10 deposition, there's no reason you would be impaired
11 today or unable to give truthful testimony, such as
12 for taking medication or something like that?

13 A. There is not.

14 Q. Thank you. Did you review anything to
15 refresh your recollection in preparation for this
16 deposition?

17 A. I reviewed my report.

18 Q. Anything else?

19 A. Not that I recall.

20 Q. Did you have discussions with anyone in
21 preparation for today's deposition?

22 A. I had discussions with counsel.

23 Q. When were those discussions?

24 A. Over the past week we met on several
25 occasions.

1 Q. Thank you. And you cited in the report every
2 authority that you relied upon in drafting your
3 report, correct?

4 A. Yes.

5 MR. HILDABRAND: So I'll start by
6 entering what we have as Doc A. We'll have this as
7 Exhibit 1.

8 Travis, can you circulate that around.
9 You should see in chat there's a Document A,
10 Cyperski report. We're going to enter that as
11 Exhibit 1.

12 (WHEREUPON, a document was marked as
13 Exhibit Number 1.)

14 BY MR. HILDABRAND:

15 Q. Thank you. Dr. Cyperski, can you see that
16 document?

17 A. Yes, I can.

18 Q. Is this your expert report?

19 A. Yes.

20 Q. Thank you. So we're going to look at this a
21 little bit. On page one, paragraph three, do you
22 see where that is?

23 A. Yes.

24 Q. So here do you say that you reviewed the text
25 of Senate Bill 228 at issue in this matter?

1 A. Yes.

2 Q. Just to confirm, you are not an attorney,
3 correct?

4 A. That is correct.

5 Q. So you're not offering an expert legal
6 opinion on the meaning of the law, correct?

7 A. That is correct.

8 Q. Later in paragraph three you say that you
9 relied on professional guidelines and scientific
10 literature in the pertinent fields. Is the
11 pertinent field for you psychology?

12 A. Yes.

13 Q. And you are testifying as an offered expert
14 in psychology; is that correct?

15 MS. BROWN: Objection.

16 THE WITNESS: So my expert report is
17 around gender identity and including the guidelines.
18 And considering gender dysphoria my expertise is as
19 a mental health professional and psychologist.

20 BY MR. HILDABRAND:

21 Q. A medical professional and psychologist. Can
22 you be more specific? What as a medical
23 professional? Are you a psychiatrist?

24 A. I am sorry. I believe I said a mental health
25 professional --

1 Q. Okay.

2 A. -- in which I am a psychologist.

3 Q. So you're not offering an expert opinion in
4 psychiatry?

5 A. That is correct.

6 Q. What is the difference between psychology and
7 psychiatry?

8 A. So psychologists tend to rely on more talk
9 therapy and in reviewing literature and research
10 related to mental health broadly. Psychiatrists in
11 practice are specifically MDs and focus on
12 prescription of medication to treat psychiatric
13 conditions.

14 Q. And you mentioned the guidelines. Are you an
15 expert in the WPATH Standards of Care?

16 A. I rely on these guidelines in my work.

17 Q. Thank you. And would other psychologists
18 look to the most recent WPATH Standards of Care as
19 well?

20 MS. BROWN: Objection.

21 THE WITNESS: I'm sorry, can you repeat
22 the question?

23 BY MR. HILDABRAND:

24 Q. Do psychologists rely upon the WPATH
25 Standards of Care?

1 A. At this time, WPATH Standards of Care are
2 professional guidelines for mental health
3 professionals and medical professionals that are
4 specializing in working with individuals from the
5 transgender community and who experience gender
6 dysphoria.

7 Q. Do you rely upon the most current WPATH
8 Standards of Care in your practice?

9 A. I do.

10 Q. And you joined WPATH last year, 2021,
11 correct?

12 A. I believe that's correct, yes.

13 Q. Let's go to I think it's page 12 in the PDF.
14 Page two in the CV. Do you see?

15 MS. BROWN: Sorry. Clark, if you'll
16 give me one second, we're still scrolling.

17 MR. HILDABRAND: Of course. No problem.

18 MS. BROWN: Okay. We're on page two.
19 Where would you like her to look?

20 BY MR. HILDABRAND:

21 Q. Do you see where it says professional
22 organizations?

23 A. Yes.

24 Q. Does it list your membership in WPATH?

25 A. It does.

1 Q. When is the start date?

2 A. It lists 2021.

3 Q. Through present, correct?

4 A. Correct.

5 Q. Thank you. So let's take a step back and
6 talk about your education. So this is going to be
7 on page 11 of the PDF, page one of the CV, if y'all
8 could scroll there.

9 MS. BROWN: Okay.

10 BY MR. HILDABRAND:

11 Q. Where did you go to college?

12 A. I attended Danville University, Granville,
13 Ohio.

14 Q. What did you major in there?

15 A. I majored in psychology.

16 Q. And then where did you earn your M.S. degree?

17 A. I earned my Master's at Auburn University in
18 Auburn, Alabama.

19 Q. So just curious, working at Vandy, are you
20 more of a War Eagle or a Commodore, or are you
21 really not much a sports person?

22 A. My heart would be in the Southeastern
23 Conference with Auburn.

24 Q. Fair enough. I see here you wrote a thesis
25 at Auburn for your M.S.; is that correct?

1 A. That is correct.

2 Q. Was that thesis required to earn your M.S.?

3 A. Yes.

4 Q. Did professors review and approve your
5 thesis?

6 A. Yes.

7 Q. Then you received your Ph.D. in clinical
8 psychology from Auburn as well; is that correct?

9 A. That is correct.

10 Q. What was your thesis on for your Ph.D.?

11 A. My dissertation for my Ph.D. was looking at
12 the therapeutic alliances across the milieu. And
13 these would be implications and challenges working
14 with adjudicated adolescent males in residential
15 treatment.

16 Q. Okay. Thank you. During your education at
17 Tennessee University, did you receive education in
18 transgender psychology?

19 MS. BROWN: Objection to form.

20 THE WITNESS: So I received my education
21 at Auburn University.

22 BY MR. HILDABRAND:

23 Q. Yes. During your undergrad -- while
24 receiving your undergraduate degree, your B.S. in
25 psychology at Denison University, did you receive

1 any education there in transgender psychology?

2 MS. BROWN: Same objection.

3 THE WITNESS: I do not recall the
4 specifics of my coursework at Denison. But I do not
5 recall specifically learning about transgender
6 psychology.

7 BY MR. HILDABRAND:

8 Q. While receiving your M.S. and Ph.D. at
9 Auburn, did you receive education in transgender
10 psychology?

11 MS. BROWN: Objection to form.

12 THE WITNESS: So in my doctoral study at
13 Auburn University, part of the curriculum, including
14 a semester-long course, was focused on clinical
15 competencies with diverse populations on cultural
16 considerations, which would include professions and
17 content related to the LGBTQ+ community and the
18 transgender community.

19 BY MR. HILDABRAND:

20 Q. Is what you learned there consistent with
21 your report in this case?

22 A. So my understanding and professional
23 expertise that was utilized to draft the report has
24 been developed over time, including through
25 continuing education and professional experience

1 post-graduation.

2 Q. And you received your Ph.D. in 2016; is that
3 correct?

4 A. Yes, that is correct.

5 Q. How many years ago was that?

6 A. I believe it was seven years ago.

7 Q. So 2016 was seven years ago from now?

8 A. If my math is correct, yes.

9 Q. And while working toward your Ph.D., did you
10 have pre-doctoral internship at Vanderbilt?

11 A. That is correct.

12 Q. Did you also have a doctoral fellowship at
13 Vanderbilt University Medical Center?

14 A. Yes.

15 Q. And that's where you work today, correct?

16 A. Correct.

17 Q. Thank you. I know some of these questions
18 are basic but we just have to get out of the way.
19 And have you worked at the Vanderbilt Pediatric and
20 Adolescent Transgender Health Clinic since the
21 clinic opened in 2018?

22 A. That is correct.

23 Q. Is that clinic referred to as the acronym
24 VPATH?

25 A. Yes.

1 Q. So VPATH sounds similar to WPATH. Does VPATH
2 follow WPATH's approach to transgender medicine?

3 MS. BROWN: Objection to form.

4 THE WITNESS: So we are an
5 interdisciplinary clinic that relies on multiple
6 standards of care, including the WPATH Standards of
7 Care and the Endocrine Society.

8 BY MR. HILDABRAND:

9 Q. Do the WPATH Standards of Care and the
10 Endocrine Society Guidelines conflict?

11 MS. BROWN: Objection to form.

12 THE WITNESS: Those guidelines from the
13 Endocrine Society and the WPATH are long documents.
14 They are often in agreement with one another but may
15 have points in which there is conflicting
16 information within the hundreds of pages that are
17 present.

18 BY MR. HILDABRAND:

19 Q. If there is a conflicting recommendation
20 between the WPATH Standards of Care and the
21 Endocrine Guidelines, is there one or the other that
22 you would prefer?

23 MS. BROWN: Objection to form.

24 THE WITNESS: My experience is that it
25 would be up to the treatment team and the particular

1 specialist that was making a decision about care
2 which guidelines they would refer to specifically
3 and rely on more.

4 MS. BROWN: Clark, I have a quick
5 question, so I don't mean to interrupt. Do you want
6 us to still be looking at the exhibit? Because when
7 we are looking at it, it's taking up the whole
8 screen, so we're not the seeing the Zoom. I'm just
9 flagging that for you.

10 MR. HILDABRAND: You don't have to keep
11 looking at it if you don't want to right now. But
12 we'll return to it in just a second. So we'll leave
13 it up there.

14 MS. BROWN: So leave it up.

15 BY MR. HILDABRAND:

16 Q. You mentioned that the provider would choose
17 between the two of those. Is that up to their
18 discretion to decide which is appropriate?

19 MS. BROWN: Objection to form.

20 THE WITNESS: The provider would rely on
21 their expertise and scientific knowledge, as well as
22 that assessment and collaboration with the patient
23 and their guardian to determine an appropriate
24 treatment plan and review of the guidelines.

25 / /

1 BY MR. HILDABRAND:

2 Q. Do you provide service at VPATH inconsistent
3 with both WPATH and the Endocrine Guidelines?

4 MS. BROWN: Objection to form.

5 THE WITNESS: I just want to make sure I
6 heard the question correctly. Did you say
7 consistent or inconsistent? Could you repeat,
8 please?

9 BY MR. HILDABRAND:

10 Q. So we have discussed situations where there
11 might be conflict or tension between the two. Would
12 there be any scenario where you would provide
13 service to the patient that would be inconsistent
14 with both the Endocrine Guidelines and the WPATH
15 Standards of Care?

16 MS. BROWN: Same objection.

17 THE WITNESS: We rely on the
18 Endocrine Society Guidelines and the WPATH
19 Guidelines to inform our practice. Treatment is
20 individualized to meet the needs of each individual
21 patient and their caregiver.

22 BY MR. HILDABRAND:

23 Q. Could it be individualized not to follow
24 either the Endocrine Guidelines or the WPATH
25 Standards of Care?

1 MS. BROWN: Objection to form.

2 THE WITNESS: Not that I'm aware of.

3 BY MR. HILDABRAND:

4 Q. Thank you. So turning back to the report,
5 we're going to go up to the bottom of page two, top
6 of page three. This is paragraph eight.

7 A. We are scrolling.

8 Q. Thank you.

9 MS. BROWN: Can you see that?

10 THE WITNESS: Yes. We are at the bottom
11 of page two.

12 BY MR. HILDABRAND:

13 Q. All right. At the top of page three, do you
14 see where it says: VPATH is an interdisciplinary
15 clinic bringing together practitioners from
16 endocrinology, psychology, primary care, and other
17 fields provide comprehensive care to transgender
18 children, adolescents, and their families; is that
19 correct?

20 A. Yes.

21 Q. Just for the record, you are not an
22 endocrinologist, correct?

23 A. I am not an endocrinologist.

24 Q. And you are not a primary care doctor,
25 correct?

1 A. I am not a primary care physician.

2 Q. So you are not offering expert testimony
3 about endocrinology?

4 MS. BROWN: Objection to form.

5 THE WITNESS: I am offering expert
6 testimony around my role and experience as a
7 psychologist and mental health professional. A part
8 of that work, particularly in the VPATH Clinic, we
9 collaborate very closely with our interdisciplinary
10 team of providers, including endocrinologists,
11 primary care physicians, and other providers as
12 well.

13 BY MR. HILDABRAND:

14 Q. I understand that you may collaborate with
15 them, but you are not an endocrinologist, correct?

16 A. I am not an endocrinologist, no.

17 Q. So do you offer an expert opinion about
18 endocrinology? Yes or no?

19 A. I do not offer an expert opinion about
20 endocrinology, although there may be some aspects of
21 endocrinology practice that are represented in the
22 Endocrine Society Guidelines or the WPATH that are
23 pertinent to my practice as a mental health
24 professional.

25 Q. And as we mentioned, you are not a primary

1 care physician. Are you offering expert testimony
2 as a primary care physician?

3 A. No, I am not.

4 Q. Thank you. So turning down to -- back down
5 to page 17 of the PDF. This is page seven of the
6 CV.

7 A. We are on page seven of the CV.

8 Q. Does this list community and professional
9 education activities?

10 A. Yes. These are community and professional
11 education activities which are coursework primarily
12 that I have provided to other professionals.

13 Q. I see did you provide information to the
14 Tennessee Department of Children's Services
15 otherwise called DCS?

16 A. Yes.

17 Q. When was that?

18 A. In my role at Vanderbilt University Medical
19 Center, I have partnered closely with the Department
20 of Children's Services since starting my
21 pre-doctoral internship in 2016.

22 Q. And I see the dates for the Child Protective
23 Services Supervisor Academy. Was that from 2020 to
24 2021?

25 A. Yes.

1 Q. But then also the Child Protective Services
2 Academy was 2015 to 2020; is that correct?

3 A. That is correct.

4 Q. So in providing this guidance to CPS, are you
5 using the same sort of psychological expertise that
6 you're using to testify in this case?

7 MS. BROWN: Objection to form.

8 THE WITNESS: In my work with the
9 Department of Children's Services, I rely on my
10 professional expertise working in trauma influence
11 care and as a licensed clinical psychologist with
12 expertise in child and adolescent psychology.

13 BY MR. HILDABRAND:

14 Q. So you use your expertise as a psychologist
15 and mental health provider?

16 A. Yes.

17 Q. Have you given presentations to the Tennessee
18 Department of Children's Services?

19 A. Yes, I have.

20 Q. Do you still give presentations to DCS?

21 A. I do.

22 Q. When was the last presentation you remember
23 giving to DCS?

24 A. I believe my last presentation with the
25 Department of Children's Services was in May or June

1 of this year.

2 Q. Thank you. So going back up in your report
3 to page one, paragraph two, so all the way back in
4 the beginning. Are y'all there?

5 A. Almost.

6 MS. BROWN: We'll let you know when
7 we're there.

8 BY MR. HILDABRAND:

9 Q. Thank you.

10 A. We are on page one of the report.

11 Q. Thank you. So do you see where it says
12 you've been asked to provide your expert opinion on
13 gender identity, gender dysphoria in children,
14 adolescents, the treatment of gender dysphoria, and
15 the impact of laws like Senate Bill 228, Tennessee's
16 legislative ban on transgender middle and high
17 school students for participating on interscholastic
18 sports teams consistent with your gender; is that
19 what you said there?

20 A. It is.

21 Q. Are those the subjects you opine on in your
22 expert report?

23 A. They are.

24 Q. No other topics?

25 MS. BROWN: Objection to form.

1 THE WITNESS: Those are the topics that
2 I addressed through my expert report.

3 BY MR. HILDABRAND:

4 Q. And just to go back on to expertise, you're
5 also not a sports physiologist, correct?

6 A. I am not a sports physiologist, no.

7 Q. You are not an expert in exercise science,
8 correct?

9 A. I am not.

10 Q. So turning to page three in the report,
11 paragraph 13?

12 A. We're there.

13 Q. Thank you. So you say here: At birth, most
14 people are assigned a sex, typically male or female
15 based solely on the appearance of their external
16 genitalia; is that correct?

17 A. Yes.

18 Q. And you did not offer an alternative
19 definition of sex in your report, correct?

20 MS. BROWN: Objection to form.

21 THE WITNESS: This statement reflects
22 that people are assigned a sex at birth typically
23 based on the appearance of their external genitalia.

24 BY MR. HILDABRAND:

25 Q. Do you provide a definition of sex other than

1 this one here in your report?

2 MS. BROWN: Objection to form.

3 THE WITNESS: I do not offer a
4 definition of sex in the report outside of this,
5 although there are other understandings and can
6 provide additional information about a definition.

7 BY MR. HILDABRAND:

8 Q. But you did not mention other understandings
9 of sex in your report, correct?

10 MS. BROWN: Same objection.

11 BY MR. HILDABRAND:

12 Q. And feel free to look through your report and
13 point me to somewhere if you did.

14 A. Not that I am aware of.

15 MS. BROWN: Do you want to take a moment
16 to go through it?

17 THE WITNESS: I'm happy to take a moment
18 to look through just in case.

19 MS. BROWN: Clark, we'll let you know.
20 We are going to scroll and come back and then she'll
21 answer your question. Okay.

22 BY MR. HILDABRAND:

23 Q. Thank you.

24 A. So we finished reviewing the document and
25 there are references to sex assigned at birth, which

1 is what my field primarily uses to discuss an
2 individual's sex assigned at birth. So the
3 definition of sex may be more complicated and
4 nuanced than that, particularly within the medical
5 community.

6 Q. Just for the benefit of the transcript, you
7 spent the past several minutes reviewing your expert
8 report, correct?

9 A. That is correct.

10 Q. And you cannot point me to any page in your
11 expert report where you provide a more complex or
12 complicated definition of sex other than sex
13 assigned at birth, correct?

14 MS. BROWN: Objection to form.

15 THE WITNESS: Although there may not be
16 a more complex definition in the body of the report,
17 professional experience would suggest and happy to
18 provide more information about the complications and
19 nuances of the definition of sex.

20 BY MR. HILDABRAND:

21 Q. Even if that's the case, you did provide a
22 more complex definition of sex in the report,
23 correct?

24 MS. BROWN: Objection to form.

25 THE WITNESS: In my report primarily

1 referring to sex assigned at birth and the concept
2 of being assigned a sex at birth.

3 BY MR. HILDABRAND:

4 Q. You say primarily. Is there anywhere else
5 that you refer to sex other than sex assigned at
6 birth? Yes or no?

7 MS. BROWN: Objection to form.

8 THE WITNESS: The convention in the
9 field is to refer to sex assigned at birth.

10 BY MR. HILDABRAND:

11 Q. So, sorry. I need you to answer the
12 question. Did you use a definition of sex other
13 than sex assigned at birth in your expert report?
14 Yes or no?

15 MS. BROWN: Objection to form.

16 THE WITNESS: I used terminology
17 consistent with sex assigned at birth.

18 BY MR. HILDABRAND:

19 Q. Did you use any other terminology in your
20 expert report that you spent several minutes
21 reviewing?

22 MS. BROWN: Same objection.

23 THE WITNESS: No.

24 BY MR. HILDABRAND:

25 Q. Thank you. In your expert report, did you

1 use the words "biology" or "biological"? And,
2 again, feel free if you need to take a few minutes
3 to review your expert report.

4 A. Yes. We'll need to take a few minutes.

5 Q. Of course.

6 MS. BROWN: And just let me know when
7 you'd like me to scroll.

8 THE WITNESS: Okay. Scroll. You can
9 scroll further. Can you scroll down. Scroll down.
10 Please scroll down. Okay. You can scroll.

11 BY MR. HILDABRAND:

12 Q. Have you reviewed your report, or are you
13 still looking over?

14 MS. BROWN: Again, Clark, we'll let you
15 know when we have finished reviewing it. You gave
16 her the offer to review it for the specific words
17 that you mentioned and that's what we're doing.
18 Okay?

19 BY MR. HILDABRAND:

20 Q. That's perfectly fine. I didn't know if I
21 had missed you saying you were finished, so take as
22 much time as you need.

23 A. Thank you. Scroll down. Okay. You can
24 scroll. Go to the next page. Okay. You can
25 scroll. You can scroll. You can scroll.

1 MS. BROWN: Okay. We reviewed.

2 THE WITNESS: Can you repeat the
3 question for me?

4 BY MR. HILDABRAND:

5 Q. Do you do not use the words "biological" or
6 "biology" anywhere in your expert report, correct?

7 MS. BROWN: Objection to form.

8 THE WITNESS: I do not appear to use the
9 word "biology", though aspects of biology are
10 represented in the report.

11 BY MR. HILDABRAND:

12 Q. And you did not use the word -- just for the
13 record, you did not use the word "biological"
14 either, correct?

15 MS. BROWN: Same objection.

16 THE WITNESS: Same as previous answer.
17 The word "biological" is not captured but aspects of
18 biology or biological consideration are discussed.

19 BY MR. HILDABRAND:

20 Q. Thank you. So getting back to sex assigned
21 at birth, is sex assigned at birth or identified at
22 birth?

23 MS. BROWN: Object to the form.

24 THE WITNESS: The terminology we use in
25 the field is sex assigned at birth or sometimes sex

1 designated at birth.

2 BY MR. HILDABRAND:

3 Q. And who makes that assignment?

4 A. Typically sex is assigned by the physician
5 and medical team delivering a baby.

6 Q. If there's no physician when the baby is
7 delivered, which I know nowadays people deliver most
8 babies in hospitals, but imagine you're in a
9 situation where there's no doctor present when the
10 baby is born. When the baby is born, before anyone
11 has said a word, does the baby already have a sex?

12 MS. BROWN: Objection to form.

13 THE WITNESS: An individual sex can be
14 determined by many different factors. It is often
15 based on the appearance of external genitalia which
16 may be visible in some cases at birth.

17 BY MR. HILDABRAND:

18 Q. To get back to the question, before anyone in
19 the room says a word to say what the baby's sex is,
20 does the baby already have a sex?

21 MS. BROWN: Same objection.

22 THE WITNESS: At birth a baby has
23 aspects of their sex. However, their sex in this
24 context and by definition is assigned at birth.

25 / /

1 BY MR. HILDABRAND:

2 Q. So if a baby born has XY chromosomes, has a
3 penis, has no disorder of sexual development, is
4 born, before any doctor says a word what is the sex
5 of that baby?

6 MS. BROWN: Objection to form.

7 THE WITNESS: So from that scenario it's
8 hard to give an answer because, for example, many
9 individuals with a disorder of sexual development or
10 a DSD would not be available and/or detected at
11 birth. So sex may be assigned at birth based on the
12 appearance of the child's external genitalia.

13 BY MR. HILDABRAND:

14 Q. In the question I said a baby who does not
15 have a DSD, a baby who is born with XY chromosomes,
16 has a penis, has no DSD, they are born, they are
17 sitting there, no doctor, the mother, the father, no
18 one has said a word, does the baby already have a
19 sex?

20 MS. BROWN: Objection to form.

21 THE WITNESS: I'm sorry, I have to
22 reject the question because a DSD would often be
23 determined later in life. It would not necessarily
24 be detectable at birth.

25 / /

1 BY MR. HILDABRAND:

2 Q. So rather than fighting the hypothetical,
3 assume that later in life the baby is determined not
4 to have a DSD, even back then when the baby was
5 born, did the baby have a sex before anyone said a
6 word?

7 MS. BROWN: Same objection.

8 THE WITNESS: The baby has aspects of
9 sex that might include their biology of gametes and
10 chromosomes and genitalia.

11 (Court Reporter interrupts for
12 clarification.)

13 THE WITNESS: Thank you, Ms. Honeycutt.
14 So they have aspects of biology, such as their
15 gametes, their chromosomes, their genitalia, their
16 hormones. Those are present in every individual and
17 a sex is assigned at birth.

18 BY MR. HILDABRAND:

19 Q. But is it your position that the baby does
20 not have a sex until it is assigned after birth?

21 MS. BROWN: Objection to form.

22 THE WITNESS: The consensus in the field
23 is that a sex is assigned at birth.

24 BY MR. HILDABRAND:

25 Q. And that the baby does not have a sex until

1 it is assigned at birth?

2 A. In our experience and the way that we
3 conceptualize cases, yes, sex is assigned at birth.

4 Q. And to return to the question, so there is no
5 sex until it is assigned at birth?

6 MS. BROWN: Objection to form.

7 THE WITNESS: Sex is assigned at birth.

8 BY MR. HILDABRAND:

9 Q. Can you please answer the question yes or no.
10 Is there a sex before it is assigned at birth?

11 A. It's very hard to answer as a yes or no
12 because sex is a construct made of many different
13 factors and is considered based on many different
14 aspects of a person's biology and sex itself is a
15 construct.

16 BY MR. HILDABRAND:

17 Q. So you cannot say that a baby has a sex
18 before it is assigned at birth; is that correct?

19 MS. BROWN: Objection to form.

20 THE WITNESS: My opinion is that a sex
21 is assigned at birth.

22 BY MR. HILDABRAND:

23 Q. When the child is in the womb does it have a
24 sex?

25 MS. BROWN: Objection to form.

1 THE WITNESS: In the womb a sex may be
2 assigned based on review of, for example, a child's
3 external genitalia.

4 BY MR. HILDABRAND:

5 Q. And that would be before birth, correct?

6 A. So those individuals who received prenatal
7 care, yes, that would be before birth.

8 Q. So is your definition of sex really sex is
9 assigned at birth or sex is assigned when the child
10 is in the womb?

11 MS. BROWN: Objection to form.

12 THE WITNESS: Sex is assigned at birth
13 and represented on legal documents such as a birth
14 certificate.

15 BY MR. HILDABRAND:

16 Q. So if the doctor sees -- performs an
17 ultrasound -- sorry. First of all, does Vanderbilt
18 University Medical Center provide ultrasounds to
19 pregnant mothers?

20 MS. BROWN: Objection to form.

21 THE WITNESS: I'm here to represent my
22 practice. And my professional opinion, it is likely
23 that Vanderbilt University Medical Center does
24 indeed perform ultrasounds on pregnant mothers, yes.
25 / /

1 BY MR. HILDABRAND:

2 Q. So during an ultrasound, say that the mother
3 is 20 weeks pregnant with the baby -- I'm sorry.
4 Let's say 24 weeks pregnant with the baby. And the
5 doctor sees in the ultrasound that the baby has a
6 penis. They don't see any signs of a DSD being
7 present, and they say that the baby is a boy. Is
8 that accurate to say at that time that the sex of
9 the baby is male?

10 MS. BROWN: Again, objection to form.

11 THE WITNESS: You have described a
12 common experience of individuals receiving an
13 ultrasound at 24 weeks, in which a sex is assigned
14 and designated by a physician or an ultrasound tech.

15 BY MR. HILDABRAND:

16 Q. So in some cases, sex could be assigned while
17 the mother is still pregnant before birth?

18 A. A designation could be made before birth.

19 Q. So before birth we've established that you
20 could designate a sex before then. If the doctor
21 does not -- some parents don't want to know the
22 baby's sex until the baby is born. That is a common
23 occurrence.

24 Would the baby still have a sex while in the
25 womb even if the doctor has not designated what the

1 sex of the baby is?

2 MS. BROWN: Objection to form.

3 THE WITNESS: As I have shared
4 previously, there are aspects of sex which may be
5 present and the sex would be then assigned or
6 designated at birth.

7 BY MR. HILDABRAND:

8 Q. But you cannot say that the baby in the womb
9 has a sex?

10 MS. BROWN: Objection to form.

11 THE WITNESS: Again, we use the
12 terminology of sex assigned at birth.

13 BY MR. HILDABRAND:

14 Q. I understand that you use that terminology.
15 But are you telling me that the baby in the womb
16 does not have a sex even though other babies in the
17 womb could be assigned a sex?

18 MS. BROWN: Again, objection to form.
19 And, Clark, I'm just going to note that, again,
20 she's repeatedly said there are aspects of sex and
21 I'm just confused --

22 MR. HILDABRAND: I understand that's
23 what she has said, but she has not answered the
24 question that was asked. I understand that she has
25 answered the question she wanted asked, but she has

1 not answered the question that was asked.

2 THE WITNESS: Can you remind me of the
3 question that was asked then, please?

4 BY MR. HILDABRAND:

5 Q. Yes. So we have established that some babies
6 can have their sex assigned while they are in the
7 womb. Other parents do not want to learn the baby's
8 sex until the child is born. In those cases where
9 the doctor has not said this child's sex is male or
10 female, would the baby still have a sex in the womb
11 before birth?

12 MS. BROWN: Same objection.

13 THE WITNESS: My previous answer stands,
14 that a baby would have aspects of sex and that would
15 be then designated a sex at birth for those parents
16 that were not aware of what had been designated
17 previously.

18 BY MR. HILDABRAND:

19 Q. Let's go ahead and move on, then. In
20 paragraph two of your report, this is up on page
21 one.

22 A. We are there.

23 Q. Do you see where you used the word "gender",
24 consistent with their gender?

25 A. I see use of the word "gender" and consistent

1 with their gender, yes.

2 Q. So let's move forward to page three,
3 paragraph 12. Do you see where it says: A person's
4 gender identity refers to their inner sense of their
5 own gender? Again, do you use the noun --

6 A. I'm sorry, can you give us one moment?

7 Q. Of course. Take as much time as you need.

8 A. You said read paragraph 12; is that right?

9 Q. That is correct.

10 A. Okay. Paragraph 12. I see it now.

11 Q. So is the first sentence there, A person's
12 gender identity refers to their inner sense of their
13 own gender; is that correct?

14 A. That is correct.

15 Q. And you used the noun gender here at the end
16 of this sentence, correct?

17 MS. BROWN: Objection to form.

18 THE WITNESS: Gender is at the end of a
19 sentence, yes.

20 BY MR. HILDABRAND:

21 Q. And this may take some time if you want to
22 review the document. But can you review your report
23 and let me know if anywhere in your report you
24 define the noun gender?

25 MS. BROWN: Same objection. And we'll

1 take the time to review. Doctor, is there anywhere
2 you would like me to start or at the beginning?

3 THE WITNESS: We can start right here.

4 MS. BROWN: Again, just let me know when
5 to scroll.

6 THE WITNESS: Okay. Okay. We can
7 scroll. We can scroll. We can scroll further. We
8 can scroll down. We can scroll. We can scroll. We
9 can scroll further. We can scroll down. We
10 reviewed the document. Can you repeat the question?

11 BY MR. HILDABRAND:

12 Q. Of course. Thank you for reviewing it. In
13 your report, do you define the noun gender anywhere?

14 MS. BROWN: Same objection.

15 THE WITNESS: So in my report I define
16 gender identity.

17 BY MR. HILDABRAND:

18 Q. To go back to the question, did you define
19 the noun gender?

20 A. Gender is based on an individual's gender
21 identity.

22 Q. So in paragraph 12, the definition of a
23 person's gender identity refers to the inner sense
24 of their own gender. Is it your position that
25 gender itself is defined by gender identity?

1 MS. BROWN: Objection to form.

2 THE WITNESS: So here we have a
3 definition of a person's gender identity refers to
4 their inner sense of their own gender in
5 paragraph 12.

6 BY MR. HILDABRAND:

7 Q. Yes. Are gender and gender identity distinct
8 concepts?

9 A. Not that I am aware of.

10 Q. So is it your understanding that gender
11 identity and gender are the same concepts?

12 MS. BROWN: Objection to form.

13 THE WITNESS: So an individual's gender
14 identity is their sense of -- of their own gender.
15 I'm sorry, I don't think I understand what you're
16 getting at.

17 BY MR. HILDABRAND:

18 Q. Of course. So my concern is, I'm trying
19 to -- how did you define gender in your report? You
20 referred to the definition of gender identity here,
21 but what is the definition of the gender that you
22 provide in your report, or did you not provide a
23 definition of gender in your report?

24 MS. BROWN: Objection to form.

25 THE WITNESS: I provided a definition of

1 gender identity. And based on my experience and
2 review of the literature would be happy to expand
3 further and discuss the social construct that is
4 gender.

5 BY MR. HILDABRAND:

6 Q. So gender is a social construct?

7 A. Gender is a social construct that is
8 representative of many different aspects of an
9 individual's experience in the world and what's most
10 important to here is that we're talking about what
11 is a person's sense of their own gender.

12 Q. Did you define -- did you provide that
13 definition of gender in your expert report?

14 MS. BROWN: Objection to form.

15 THE WITNESS: We've established that
16 here it is a definition of gender identity.

17 BY MR. HILDABRAND:

18 Q. Yes. I think we have established that you
19 provided a definition of gender identity. Please
20 point me to the page in your report where you define
21 the word "gender", not the word "gender identity",
22 the word "gender".

23 A. So although there may not be a definition of
24 gender specific in the pages of this report, I'm
25 happy to provide an opinion and information about

1 that definition based on some of the same things
2 that were used to draft the report, which would
3 include review of the literature and my professional
4 experience.

5 Q. Before we do that, can you point me to the
6 paragraph in your report where you define the word
7 "gender" or did you not define the word "gender" in
8 your report?

9 MS. BROWN: Objection to form.

10 THE WITNESS: My experience is that
11 gender is best understood by a person's inner sense
12 of their own gender and gender identity. And so I
13 believe that it is captured in this report by
14 reflecting an individual's inner sense of their
15 gender.

16 BY MR. HILDABRAND:

17 Q. Which paragraph in this report defines
18 gender?

19 A. Here we are looking at paragraph 12, which
20 refers to gender identity and the importance of an
21 individual's inner sense.

22 Q. So this is your definition of gender in your
23 report?

24 MS. BROWN: Objection to form.

25 THE WITNESS: This is a definition of

1 gender identity and the construct and importance of
2 an individual's inner sense. There may be other
3 information that we can use to break down or to
4 understand the noun gender specifically if that
5 would be helpful.

6 BY MR. HILDABRAND:

7 Q. Do you break down the word "gender" in
8 paragraph 12?

9 A. I do not.

10 Q. Thank you. And there is no other paragraph
11 in this report that breaks down the word "gender",
12 correct?

13 MS. BROWN: Objection to form.

14 THE WITNESS: In the report, there is no
15 additional information about the definition of the
16 term "gender".

17 BY MR. HILDABRAND:

18 Q. Thank you. I'm glad we got there.

19 MS. BROWN: We've been going about an
20 hour, so we'd like a ten-minute break when it's
21 convenient for you. If you have another question
22 that you want to ask...

23 MR. HILDABRAND: That's a great place to
24 pause for me. Glad to go off the record.

25 MS. BROWN: Okay. Thank you.

1 (Recess observed.)

2 BY MR. HILDABRAND:

3 Q. Turning back to your expert report,
4 Exhibit 1, Doc A. We are going to go to
5 paragraph 13, which straddles pages three and four.

6 A. Okay. Paragraph 13. We are there.

7 Q. Great. Do you see where you write that:
8 Non-transgender people, also referred to as
9 cisgender people, have a gender identity that aligns
10 with their sex assigned at birth. Transgender
11 people have a gender identity that is incongruent
12 within the sex they were assigned at birth. Is that
13 what you wrote here?

14 A. Yes. That's what's in my report.

15 Q. And do you still agree with that statement?
16 And feel free to answer and explain further as you
17 need.

18 A. I believe the report captures the definition
19 of cisgender people and transgender people.

20 Q. So are there two categories, cisgender people
21 on the one hand and transgender people on the other
22 hand; is that correct?

23 MS. BROWN: Objection to form.

24 THE WITNESS: In the report, I'm
25 offering definitions of cisgender and transgender.

1 However, in the current terminology, there are many
2 categories of a gender identity.

3 BY MR. HILDABRAND:

4 Q. So are there additional categories besides
5 transgender and cisgender?

6 MS. BROWN: Object to the form.

7 THE WITNESS: Our terminology is often
8 evolving and changing, and there are other gender
9 identities that people may have, yes.

10 BY MR. HILDABRAND:

11 Q. So going back up a little bit to
12 paragraph 12, on page three, do you see the last
13 sentence: Every person has a gender identity? Is
14 that what you wrote?

15 A. That is in the report, yes.

16 Q. So do you still agree today that every person
17 has a gender identity?

18 A. Yes, every person has a gender identity.

19 Q. Does every person have just one gender
20 identity?

21 MS. BROWN: Objection to form.

22 THE WITNESS: So the terminology that an
23 individual may use to describe their own gender
24 identity may reflect multiple identities and yet we
25 each have a sense of our own gender, as written in

1 the report, right, that define our gender identity.

2 BY MR. HILDABRAND:

3 Q. So just to make sure I'm understanding you,
4 it could be that they have one sense but they could
5 sense that they have multiple identities?

6 MS. BROWN: Objection to form.

7 THE WITNESS: So I'm sharing that a
8 person has a gender identity that refers to their
9 own sense of gender, and what terminology or
10 understanding of their gender is is unique to each
11 individual.

12 BY MR. HILDABRAND:

13 Q. So if it's unique to each individual, have
14 you ever encountered someone who claims to have
15 multiple gender identities?

16 MS. BROWN: Objection to form.

17 THE WITNESS: I have met individuals in
18 my clinical practice who identify as gender fluid.

19 BY MR. HILDABRAND:

20 Q. Can you explain what gender fluid means?

21 A. Gender fluid is a gender identity in which an
22 individual may have an inner sense of gender that is
23 consistent with male, female, neither, or both, and
24 that that may fluctuate over time.

25 / /

1 BY MR. HILDABRAND:

2 Q. You said a minute ago that gender identity is
3 unique. How many gender identities would you
4 estimate there are?

5 MS. BROWN: Objection to form.

6 THE WITNESS: I do not currently have a
7 way to quantify the number of gender identities.
8 Again, the terminology is often changing and being
9 updated and there may be many gender identities or
10 individual gender identity may have an understanding
11 or a terminology that has not yet been published or
12 used by others.

13 BY MR. HILDABRAND:

14 Q. Fair enough. Just to get a sense of the
15 numbers that we are talking about, are there more
16 than two gender identities that you've encountered?

17 A. Yes, there are more than two gender
18 identities.

19 Q. Are there more than three gender identities?

20 A. There are more than three gender identities.
21 In fact, there's an infinite number of gender
22 identities.

23 Q. Thank you. Going down to paragraph 16 in
24 your report. This is on page four.

25 A. Did you say paragraph 16?

1 Q. Yes.

2 A. Is that correct? Okay. Yes, we're there.

3 Q. So do you cite the American Psychiatric
4 Association's Diagnostic and Statistical Manual of
5 Mental Disorders, Fifth Edition, Text Revision? Do
6 you cite that in that paragraph?

7 A. Yes, that is referenced. Yes.

8 Q. Who publishes the DSM?

9 A. The American Psychiatric Association.

10 Q. Do you use that in your practice?

11 A. It is common and part of the best practice in
12 mental health to rely on the DSM.

13 Q. And that's published by the American
14 Psychiatric Association, right?

15 A. Yes, it is published by the American
16 Psychiatric Association.

17 Q. And you not a psychiatrist, correct?

18 A. I am not a psychiatrist, although I am very
19 familiar and well trained in the DSM, and it is part
20 of our best practice as psychologists, as perhaps
21 individuals with Master's degrees who have other
22 backgrounds in mental health, to rely on and use the
23 DSM.

24 Q. So it's common for nonpsychiatrists, like
25 psychologists or other individuals you described, to

1 use the DSM as well?

2 A. Yes.

3 Q. How does -- does the DSM 5 use the term
4 "gender dysphoria"?

5 A. It does.

6 Q. Are you aware of previous editions of the DSM
7 using other terminology to refer to that?

8 MS. BROWN: Objection to form.

9 THE WITNESS: It says: Previous
10 editions of the DSM, which are no longer considered
11 valid and appropriate in the field, refer to other
12 disorders by other names.

13 BY MR. HILDABRAND:

14 Q. Was the phrase "gender identity disorder" one
15 of the terms previously used in earlier editions of
16 the DSM?

17 A. It was previously used.

18 Q. But since the DSM Edition 5 published in
19 2013, is that phrase no longer commonly used?

20 A. That is correct.

21 Q. Is one of the treatments for gender dysphoria
22 in the DSM surgery?

23 MS. BROWN: Objection to form.

24 THE WITNESS: We could reference the DSM
25 specifically. How the DSM is used is often to

1 outline a list of symptoms and psychological or
2 psychosocial diagnoses that are the label to
3 describe a symptom cluster. There is additional
4 information in the DSM about backgrounds of
5 disorders and how the symptoms may have been derived
6 as a cluster.

7 BY MR. HILDABRAND:

8 Q. Have any of your patients in your practice
9 received surgery as treatment for gender dysphoria?

10 MS. BROWN: Again, objection to form.

11 THE WITNESS: In my practice, I have
12 worked with adolescents and young adults who have
13 received surgical interventions as one aspect of
14 their treatment for gender dysphoria.

15 BY MR. HILDABRAND:

16 Q. So surgical intervention can be one aspect of
17 treating gender dysphoria?

18 MS. BROWN: Objection to form.

19 THE WITNESS: The interventions and
20 treatment plan for individuals with gender dysphoria
21 is unique to each individual and surgery may be one
22 component of their treatment plan.

23 BY MR. HILDABRAND:

24 Q. Are there any other mental health issues that
25 you are aware of that are treated with surgery?

1 MS. BROWN: Objection to form.

2 THE WITNESS: Yes, I'm aware of other
3 mental health conditions that may be treated with
4 surgery.

5 BY MR. HILDABRAND:

6 Q. Would body dysmorphic disorder be treated
7 with surgery or is surgery one option for treating
8 body dysmorphic disorder?

9 MS. BROWN: Objection to form.

10 THE WITNESS: Body dysmorphic disorder
11 an individual may wish to seek surgery as part of
12 the diagnosis and experience of body dysmorphic
13 disorder.

14 BY MR. HILDABRAND:

15 Q. Is it appropriate for health providers to
16 provide the surgical interventions that that body
17 dysmorphic individual seeks?

18 MS. BROWN: Objection to form.

19 THE WITNESS: A mental health provider
20 would not be offering surgical intervention in
21 performing those surgical interventions, no.

22 BY MR. HILDABRAND:

23 Q. Would they recommend surgical interventions
24 for or is there a scenario where a mental health
25 provider would recommend surgical interventions for

1 an individual with body dysmorphic disorder?

2 A. In my practice, I have not treated an
3 individual with body dysmorphic disorder so I cannot
4 say.

5 BY MR. HILDABRAND:

6 Q. Fair enough. Going forward a little bit to
7 page five, footnote seven.

8 MS. BROWN: I'm sorry, did you say page
9 or paragraph five?

10 BY MR. HILDABRAND:

11 Q. Page five, footnote seven.

12 A. Page five, footnote seven. Yes, we are
13 there.

14 Q. So not as a substantive question, but do you
15 cite an article here where the first author is
16 Hembree, Endocrine Treatment of Gender
17 Dysmorphic/Gender Incongruent Persons, an Endocrine
18 Society Clinical Practice Guideline?

19 A. Yes.

20 MR. HILDABRAND: Travis, can you
21 circulate, I believe it's Document B. And we will
22 mark this as Exhibit 2.

23 (WHEREUPON, a document was marked as
24 Exhibit Number 2.)

25 / /

1 BY MR. HILDABRAND:

2 Q. Can you identify what this document is?

3 A. This document is the article by Hembree, et
4 al., titled, Endocrine Treatments of Gender
5 Dysphoric, Gender-Incongruent Persons, and Endocrine
6 Society Clinical Practice Guidelines.

7 Q. And would you refer to this as the Endocrine
8 Society Guideline?

9 A. Yes.

10 Q. So let's go -- oh, before we scroll down, on
11 the list of authors, just because of this case, do
12 you see the name Joshua D. Safer?

13 A. I see that name, yes.

14 Q. So he would be one of authors on this
15 document?

16 A. It appears that way, yes.

17 Q. Thank you. All right. Scrolling down to
18 it's page 3873 in the Journal. It's page five in
19 the PDF.

20 A. We are on page five of the PDF. Yes.

21 Q. All right. Thank you. So down in the bottom
22 right-hand column, do you see the line that begins
23 yet such a classification?

24 A. Can you scroll down a little bit? Yet such a
25 classification, yes.

1 Q. I'm going to just read it out so we have a
2 copy of it. Does it say: Yet such a classification
3 does not take into account that people may have
4 gender identities outside this continuum. For
5 instance, some experience having both a male and
6 female gender identity, whereas others completely
7 renounce any gender classification. Did I read that
8 correctly?

9 A. Yes.

10 Q. Would you agree that some individuals
11 experience themselves as having both a male and
12 female gender identity?

13 MS. BROWN: Objection to form.

14 THE WITNESS: I do agree that some
15 individuals have gender identity consistent with a
16 male and female gender identity.

17 BY MR. HILDABRAND:

18 Q. And the second part of that is: Whereas
19 others completely renounce any gender
20 classification.

21 Are there some individuals that you're aware
22 of who renounce any gender classification?

23 MS. BROWN: Objection to form.

24 THE WITNESS: In the field is
25 established that others renounce gender

1 classification and labels.

2 BY MR. HILDABRAND:

3 Q. Thank you. So going on to the line, there
4 are also reports of individuals experiencing a
5 continuous and rapid involuntary alternation between
6 a male and female identity or men who do not
7 experience themselves as men but do not want to live
8 as women. So looking at the first part of that
9 sentence, do you agree that some individuals
10 experience a continuous and rapid involuntary
11 alternation between a male and female gender
12 identity?

13 A. There are some individuals who experience
14 alternations between male and female identity.

15 Q. And the second half of that sentence, are
16 there some men who do not experience themselves as
17 men but do not want to live as women; would you
18 agree with that?

19 A. I agree there are some individuals who may
20 reject the sex they were assigned at birth and do
21 not identify in a binary identity.

22 Q. So if they were born male at birth, they'd
23 reject -- make sure I'm understanding. They reject
24 being male but they don't necessarily want to be
25 female either; is that your understanding?

1 MS. BROWN: Objection to form.

2 THE WITNESS: There are individuals
3 whose sense of gender may not fall on the gender
4 binary, so who may not identify with the sex they
5 were assigned at birth or another binary gender
6 identity.

7 BY MR. HILDABRAND:

8 Q. So they wouldn't want to be a binary male or
9 female; they might want to be something else?

10 MS. BROWN: Objection to form.

11 THE WITNESS: It's not just a question
12 of what they want to be so much as who they are in
13 their gender identity.

14 BY MR. HILDABRAND:

15 Q. So would they view who they are as something
16 else besides a binary male or a binary female?

17 A. Some individuals do not identify as a binary
18 male or a binary female.

19 Q. Is that what the phrase "nonbinary" refers
20 to, or is that one understanding of what nonbinary
21 means?

22 MS. BROWN: Objection to form.

23 THE WITNESS: Individuals who identify
24 as nonbinary tend to have a gender identity that
25 exists outside the gender binary of male or female.

1 BY MR. HILDABRAND:

2 Q. Thank you for -- thanks for explaining.

3 All right. Let's go to page 11 in the PDF.
4 That's page 3879 in the way the Journal does its
5 paging.

6 A. Page 11 of the PDF. We are there.

7 Q. Before we ask about this, the
8 Endocrine Society Guideline is something that you
9 rely upon in your practice, correct?

10 A. Yes. We rely on the Endocrine Society
11 Guidelines.

12 Q. All right. On the bottom left-hand column,
13 do you see the sentence that begins, However, social
14 transition?

15 A. On the bottom of the first paragraph, yes.

16 Q. So does it say: However, social transition
17 in addition to GD/gender incongruence has been found
18 to contribute to the likelihood of persistence? Did
19 I read that accurately?

20 MS. BROWN: Objection.

21 THE WITNESS: That statement is in the
22 document and would be important to be considered in
23 context and with the evolving state of the
24 literature.

25 / /

1 BY MR. HILDABRAND:

2 Q. Feel free to explain further, but do you
3 agree with that statement?

4 MS. BROWN: Again, objection to form.
5 You read one line of this. Just noting that
6 objection.

7 BY MR. HILDABRAND:

8 Q. Would you agree that social transition is
9 likely to contribute to persistence?

10 MS. BROWN: Objection to form.

11 THE WITNESS: I am not aware of the data
12 and scientific findings that support this particular
13 claim that social transition contributes to the
14 likelihood of persistence.

15 BY MR. HILDABRAND:

16 Q. In your practice, has it been your experience
17 that social transition is likely to contribute to
18 persistence in an expressed gender identity?

19 MS. BROWN: Again, same objection.

20 THE WITNESS: In my professional
21 experience, individuals who make a social transition
22 often persist in their gender identities, including
23 because of the significant distress and
24 identification with transgender identity that
25 precipitated the social transition.

1 BY MR. HILDABRAND:

2 Q. Is social transition likely to encourage
3 persistence or does it discourage persistence?

4 MS. BROWN: Objection to form.

5 THE WITNESS: I am not aware of the
6 evidence that suggests the social transition
7 specifically contributes to persistence.

8 BY MR. HILDABRAND:

9 Q. So you wouldn't know if it is likely to or is
10 not likely to contribute to persistence?

11 MS. BROWN: Same objection.

12 THE WITNESS: Whether it is likely to or
13 not likely to is a research question that I'm not
14 aware of.

15 BY MR. HILDABRAND:

16 Q. And so that's something that you would need
17 further research on?

18 MS. BROWN: Objection to form.

19 THE WITNESS: It is important for us to
20 continue to study and to understand phenomenology in
21 all aspects of psychological mental health and
22 medical science, and understanding particulars of
23 persistence may be one area that would benefit from
24 further study.

25 / /

1 BY MR. HILDABRAND:

2 Q. Is it established in the field of psychology
3 whether social transition contributes to the
4 likelihood of persistence?

5 MS. BROWN: Objection to form. Again,
6 you've asked this question. It's been asked and
7 answered some, Clark.

8 MR. HILDABRAND: This is a different
9 question from what I asked and I had asked it
10 definitely precisely because you've objected to the
11 form several times, so I'd like her to answer the
12 question.

13 MS. BROWN: I'm just letting you know
14 I'm not hearing a different question, so I'm going
15 to continue to object.

16 MR. HILDABRAND: That fine. I'll keep
17 asking a different question.

18 BY MR. HILDABRAND:

19 Q. So is it established in the field of
20 psychology whether social transition contributes to
21 the likelihood of persistence?

22 MS. BROWN: Same objection.

23 THE WITNESS: To my knowledge and review
24 of the literature, it has not been established that
25 a social transition contributes to persistence.

1 BY MR. HILDABRAND:

2 Q. Thank you. So earlier we discussed the
3 number of gender identities. What is your opinion
4 on how many sexes there are?

5 MS. BROWN: Objection to form.

6 THE WITNESS: So to state your question,
7 that would be best directed at one of my
8 interdisciplinary colleagues. You could speak to
9 the medical aspects and definitions of sex, that
10 there may be multiple -- I'm trying to remember the
11 word that you used -- multiple sexes, for lack of a
12 better term.

13 BY MR. HILDABRAND:

14 Q. But that's not something -- to be fair,
15 that's not something you would be best situated to
16 answer?

17 MS. BROWN: Objection to form.

18 THE WITNESS: I am able to speak to an
19 individual's sex assigned at birth and how that
20 relates to their gender identity.

21 BY MR. HILDABRAND:

22 Q. But not to the question of how many sexes
23 there are?

24 MS. BROWN: Objection to form.

25 THE WITNESS: I previously stated that

1 there may be multiple sexes and that a medical
2 provider may be able provide more information.

3 BY MR. HILDABRAND:

4 Q. Different question. How many genders are
5 there?

6 MS. BROWN: Objection to form.

7 THE WITNESS: We've established that are
8 many different gender identities.

9 BY MR. HILDABRAND:

10 Q. How many different? Are there more than two?

11 A. I believe we previously established there
12 were more than three and an infinite number of
13 possibilities.

14 Q. To clarify, we previously discussed the
15 number of gender identities. How many genders, not
16 gender identities, are there? How many genders are
17 there?

18 A. So an individual gender identity is their
19 understanding of their inner sense of gender, and I
20 don't believe that those two can be separated.

21 Q. So there could also infinite genders?

22 MS. BROWN: Objection to form.

23 THE WITNESS: There are many different
24 gender identities which reflect an individual's
25 inner sense of gender, yes.

1 BY MR. HILDABRAND:

2 Q. Yes. So given as you testified earlier that
3 there can be infinite gender identities, can there
4 also be infinite genders? Please answer yes or no
5 and then feel free to elaborate.

6 A. Yes, I believe there are many different
7 gender reflected as a person's gender identity and
8 their own sense of gender.

9 Q. So to return to the question, yes or no. Can
10 there be infinite genders?

11 A. I believe I just answered that question and
12 my previous answer stands.

13 Q. Can you provide a yes or no answer to the
14 question, are there infinite genders?

15 A. My previous answer included the word yes.
16 I'm sorry if that was not legible and then an
17 ongoing explanation that an individuals' gender
18 identity, there may be many different gender
19 identities reflected of the individual's inner sense
20 of gender.

21 Q. Sorry, I'm not trying to just ask a
22 question --

23 A. I'm sorry.

24 Q. -- so I'm sorry if I misunderstood you. So I
25 just want to understand that your answer was yes,

1 there can be infinite genders and then you provided
2 a fuller explanation that explained your answer; is
3 that fair?

4 MS. BROWN: Objection to form. Again, I
5 understand, Clark, that you want a yes or no answer
6 and you can ask her that, but you can't command her
7 answer. She's going to give her answer and that's
8 her answer.

9 MR. HILDABRAND: I totally get that,
10 too, but I did request a yes or no answer and I want
11 to know what the yes or no answer was. And if she
12 says she has said a yes or no, I also don't want to
13 ask the same question again but I really would like
14 a yes or no answer to this. So yes or no --

15 MS. BROWN: But there, again, it may
16 just be a situation where, again, she's testifying
17 as an expert. She's giving her opinions and
18 answering your questions. And if she has to provide
19 context and say yes, like she did, then that's going
20 to be the answer.

21 BY MR. HILDABRAND:

22 Q. That's totally fine. At the same time, I
23 need to know what the yes or the no is, not go
24 straight into the explanation. I am happy to have
25 her provide further explanation. But I would just

1 like to know the yes or no to the question, are
2 there infinite genders? And provide any fuller
3 explanation after that, but please begin with a yes
4 or no or I don't know and then provide your fuller
5 explanation to the question are there infinite
6 genders.

7 MS. BROWN: You can answer the question
8 again, but I'm going to, again, same objection to
9 form that I have been noting.

10 THE WITNESS: So my previous answer
11 stands. Yes, there are many different gender
12 identities that are reflective of an individual's
13 inner sense of gender.

14 BY MR. HILDABRAND:

15 Q. All right. Thank you. We'll move on from
16 that. On page ten of the PDF, page 3878 in the
17 Journal's paging.

18 MS. BROWN: Sorry, what was the page
19 number?

20 BY MR. HILDABRAND:

21 Q. Of course. It's page 3878 or page ten in the
22 PDF.

23 A. Page ten of the PDF. We are there.

24 Q. And feel free -- this starts on the previous
25 page at 1.2 so feel free to read that if you want to

1 just to completely understand that. But can you
2 just read to yourself 1.2 and then I'll ask you a
3 question about part of that. But I want to make
4 sure you've been able to see the entirety of it
5 before the question. So can you please read 1.2?

6 A. Uh-huh. Scroll down. Okay. I have read
7 1.2.

8 Q. Great. And so do you see where it says that
9 one of the factors that's important is the ability
10 to make a distinction between GD/gender incongruence
11 and conditions that have similar features, e.g.,
12 body dysmorphic disorder. Can you describe for
13 us --

14 A. Yes.

15 Q. Thank you. I think we discussed this a
16 little bit earlier, but can you define for us what
17 body dysmorphic disorder is in your understanding?

18 A. My understanding of body dysmorphic disorder
19 is a diagnostic label and psychiatric condition
20 which an individual has a significant
21 misrepresentation of their body and this creates
22 distress for them.

23 Q. Is it your understanding that an appropriate
24 treatment for that misunderstanding, would an
25 appropriate treatment for that be surgery?

1 MS. BROWN: Objection to form.

2 THE WITNESS: So the specifics of body
3 dysmorphic disorder may be better left to an expert
4 in body dysmorphic disorder. I would suspect that
5 an individualized treatment plan for an individual
6 with body dysmorphic disorder would be crafted
7 between that individual and their provider and may
8 include an individual to pursue surgery.

9 BY MR. HILDABRAND:

10 Q. Are you aware of whether physicians at
11 Vanderbilt provide surgery for body dysmorphic
12 disorder?

13 A. I am not aware.

14 Q. On the right column here, do you see where it
15 says: Examples of conditions with similar features
16 are body dysmorphic disorder, bodily integrity --
17 sorry -- body identity integrity disorder, a
18 condition in which individuals have a sense that
19 their anatomical configuration as an able-bodied
20 person is somehow how wrong or inappropriate?

21 A. I see that.

22 Q. Did you see that? Okay. And then does it
23 mention eunuchism after that?

24 MS. BROWN: Sorry, Clark, you're coming
25 through very choppy. I think there's an internet

1 connection issue. We are hearing bits and pieces of
2 what you're saying.

3 BY MR. HILDABRAND:

4 Q. All right. I can hear y'all clearly. Do you
5 see on the right column --

6 A. You're speaking but we're not able to hear
7 you. I don't know if others are having the same
8 problem.

9 MR. SANDERS: I'm not having any
10 problem. I can hear everyone clearly.

11 MR. ROYER: Here as well.

12 MR. HILDABRAND: Can you hear everyone
13 else?

14 MS. BROWN: Sorry, can folks hear us?

15 MR. HILDABRAND: We can hear y'all.

16 MS. RILEY-SWANBECK: Yes.

17 MR. HILDABRAND: I think the problem may
18 be on y'all's end. Can y'all hear us?

19 MS. BROWN: I can hear you now. You're
20 coming through clear again.

21 MR. HILDABRAND: Okay. Whatever was
22 going on I'm glad it resolved. So that's how Zoom
23 works.

24 BY MR. HILDABRAND:

25 Q. On the right-hand column here, do you see

1 where it provides examples of conditions with
2 similar features are body dysmorphic disorder, body
3 identity integrity disorder? Do you see that there?

4 A. Yes.

5 Q. And then it goes on to describe eunuchism, in
6 which a person is preoccupied with or engages in
7 castration and/or penectomy for reasons that are not
8 gender identity related.

9 A. I see that.

10 Q. Is eunuchism a gender identity?

11 MS. BROWN: Objection to form.

12 THE WITNESS: Eunuchism is not a gender
13 identity that I have encountered.

14 BY MR. HILDABRAND:

15 Q. Are you aware of literature in the
16 psychological field describing eunuchism as a gender
17 identity?

18 A. I am not.

19 Q. And I assume that's -- if you're not aware, I
20 assume you're not aware of Vanderbilt treating
21 anyone with castration for eunuchism?

22 A. I am not aware.

23 Q. All right. So earlier today we've talked
24 about how you've given presentations to the
25 Tennessee Department of Children's Services using

1 your psychological expertise, right?

2 A. Yes.

3 Q. Let's turn to page 18 of Exhibit 1, your
4 expert report. This is PDF page 18. Page 18. CV
5 page eight. Do you see where you list a
6 February 27 --

7 A. We're not there quite yet. Slight
8 malfunction, so very sorry.

9 Q. No problem. Take your time.

10 A. Page 18 of the PDF. We are there.

11 Q. All right.

12 A. We are there.

13 Q. All right. Do you see where you list a
14 February 2017 presentation to DCS?

15 A. I do. Item five.

16 Q. And would that presentation reflect your
17 psychological experience?

18 MS. BROWN: Objection to form.

19 THE WITNESS: So yes. This presentation
20 was developed and delivered as a part of my
21 professional expertise.

22 BY MR. HILDABRAND:

23 Q. Just one second.

24 A. Uh-huh.

25 MR. HILDABRAND: All right. Travis, can

1 you circulate Doc C, which I think we'll mark as
2 Exhibit 3.

3 MR. ROYER: One moment. I think I --
4 Clark, you're familiar with our wonderful dual
5 authentication system. I believe that I got kicked
6 off. Give me one second.

7 MR. HILDABRAND: No problem. So what
8 would I do to share, Travis? Do I copy and paste or
9 what is the --

10 MR. ROYER: You could drag and drop or
11 just hit the little paper symbol, do you see that,
12 and skip to location there, or just drag and drop by
13 the folder.

14 MR. HILDABRAND: Thank you-all for your
15 patience with us.

16 MR. ROYER: Yes, thank you very much.

17 MS. BROWN: Of course. Of course.

18 MR. HILDABRAND: All right. I should
19 have just circulated Doc C, which we'll mark
20 exhibit -- well, sorry. What's -- we are going to
21 mark this as a cumulative exhibit with the next
22 couple. So if we can just hold off on marking it
23 for right now. But this is Doc C if y'all want to
24 pull this up.

25 MS. BROWN: Sorry, where did you

1 circulate it?

2 MR. HILDABRAND: Can y'all not see the
3 document?

4 MS. BROWN: No. There's nothing in the
5 chat.

6 MR. HILDABRAND: All right. Can we go
7 off the record for minute while we sort this out?

8 (Off-the-record discussion.)

9 BY MR. HILDABRAND:

10 Q. Thank you. Now that we're back, can you
11 please pull up Doc C?

12 A. We have it open.

13 Q. Thank you. Is that a picture of you on the
14 upper right?

15 A. Yes, that is.

16 Q. And is this you giving the presentation back
17 in February 2017?

18 A. It is.

19 Q. All right. On the left side from the
20 presentation, can you read the quotation there and
21 can you read it out loud?

22 A. Sure. So it says: Sexuality is much more
23 than sex. It's our values, attitudes, feelings,
24 interactions, and behavior. Sexual development is
25 one part of sexuality and it begins much earlier in

1 life than puberty. Infants and children may not
2 think about sexuality in the same way as adults but
3 they learn and interpret messages related to
4 sexuality that will shape their future actions and
5 attitudes.

6 Q. All right. And did you include a picture on
7 the left-hand side of the slide here?

8 A. There is a picture on the slide, yes.

9 Q. Can you please describe just for the
10 transcript what the picture depicts?

11 A. It is a picture of two children who are
12 engaged in play with what appears to be a
13 stethoscope.

14 Q. What age would you say those children are, or
15 what would be your best guess at what age those
16 children are?

17 MS. BROWN: Objection to form.

18 THE WITNESS: The children in the image
19 appear to be toddlers. I would estimate three to
20 four years of age.

21 BY MR. HILDABRAND:

22 Q. And is one of them -- does one on the left
23 appear to be a boy? Sorry. I don't know if that
24 got through. Does the child on the left appear to
25 be a boy?

1 MS. BROWN: Objection to form.

2 THE WITNESS: So I cannot make
3 assumptions of their gender identity. The child on
4 the left has stereotypically short hair and is
5 wearing a striped shirt. They are also wearing pink
6 glasses.

7 BY MR. HILDABRAND:

8 Q. And the child on the right, how would you
9 describe their features or how would society
10 describe -- are they stereotypically a girl?

11 MS. BROWN: Again, objection to form.

12 THE WITNESS: I could not assume this
13 child's gender identity. They appear to be wearing
14 a pink shirt, to have longer hair that is styled in
15 pigtails.

16 BY MR. HILDABRAND:

17 Q. And the child on the right, is that child
18 holding up the child's shirt?

19 A. The child on the right is holding up their
20 own shirt, yes.

21 Q. And the child on the left, is that child
22 touching the child on the right anywhere?

23 A. In my interpretation of the image, it appears
24 as though the child on the left is holding a
25 stethoscope and perhaps touching the stethoscope but

1 does not appear to be touching the child on the
2 right.

3 Q. Thank you for providing that description.
4 Around where on the child in the right's body is the
5 child on the left placing the stethoscope?

6 A. The child on the left is placing the
7 stethoscope on approximately the child on the
8 right's chest.

9 Q. Thank you. Why did you select this picture
10 for this slide?

11 A. This was many years ago, back in 2017, so
12 I'll do my best to estimate why I selected that at
13 the time. It is likely because this image
14 represented typical play in childhood and which many
15 toddlers and young children will play doctor or
16 house in their imaginary play.

17 MR. HILDABRAND: All right. Travis, can
18 you circulate Doc D.

19 MS. BROWN: Clark, before you do that,
20 for the record, I'd like to clarify. Is the quote
21 that you had Dr. Cyperski read attributable to the
22 source at the bottom of the slide, which says
23 National Sexual (inaudible) Center 2013?

24 (Court Reporter interrupts for
25 clarification.)

1 MS. BROWN: Yes, I'll say it again.
2 Clark, again, to clarify for the record, the quote
3 that you had Dr. Cyperski read, is that attributable
4 to the source at the bottom of the quote on the
5 slide and in parentheses it says: National Sexual
6 Violence Resource Center 2013?

7 BY MR. HILDABRAND:

8 Q. So just to clarify the record, you're
9 citing -- you're quoting this source on the slide,
10 correct?

11 MS. BROWN: I am asking if it's
12 attributable to that source? Is that where you
13 pulled the quote from that you had
14 Dr. Cyperski read? Did you hear my question? Are
15 we having audio issues again? Can folks hear me?

16 MR. HILDABRAND: I can hear you. I
17 can't hear Dr. Cyperski.

18 MS. BROWN: Dr. Cyperski didn't say
19 anything. I'm asking you about the quote that
20 you've put on the slide and the source of the slide.

21 BY MR. HILDABRAND:

22 Q. So depositions are asking the witness
23 questions, not asking other attorneys, so let's ask
24 the witness. Did she pull this quotation from the
25 National Sexual Violence Resource Center? It says

1 on the slide -- is that where you pulled the
2 quotation from?

3 A. That would be my assumption on how the slide
4 is developed. But the quotation that was read
5 previously is attributed to the source from the
6 national Sexual Violence Resource center in 2013.

7 MR. HILDABRAND: Thank you. Does that
8 clear things up?

9 MS. BROWN: It does. And for the
10 record, I'll just state that, again, this was a
11 slide and exhibit that you prepared and a source
12 that you included. And of course you're right, the
13 witness is here to answer questions, but I just want
14 to note that I asked you that question.

15 MR. HILDABRAND: And you of course have
16 an opportunity to ask questions later on as well but
17 I'm glad we can have it as accurate for the record
18 as possible. All right.

19 BY MR. HILDABRAND:

20 Q. Let's turn to Doc D which was circulated. So
21 does this also depict you on the right?

22 MS. BROWN: Sorry. Give us one moment.

23 BY MR. HILDABRAND:

24 Q. Okay.

25 A. This is an image of me on the right.

1 Q. And is it, again, the slide presentation on
2 the left?

3 A. That is correct.

4 Q. So the left column, does it have a column
5 that says stage of development?

6 A. Yes.

7 Q. And then underneath that, does it say early
8 childhood, age two to five?

9 A. It does.

10 Q. And then there's a column in the middle that
11 says common behavior; is that correct?

12 A. Yes.

13 Q. And then a column on the right that says
14 caregiver tasks; is that correct?

15 A. Yes.

16 Q. Is one of the caregiver tasks for two- to
17 five-year-olds to provide basic information about
18 reproduction?

19 A. And it's listed as the first bullet point.

20 Q. And is consensual and playful exploration
21 with peers, e.g., playing doctor, is that in the
22 common behavior column?

23 A. It is.

24 Q. So do you agree today that consensual and
25 playful exploration with peers, e.g., playing

1 doctor, is a common behavior for two- to
2 five-year-olds?

3 MS. BROWN: Objection to form.

4 THE WITNESS: Children in early
5 childhood often engage in consensual and playful
6 exploration with peers in a variety of ways.

7 BY MR. HILDABRAND:

8 Q. So to provide a yes or no answer, is it
9 common behavior, yes or no, for two- to
10 five-year-olds to engage in consensual and playful
11 exploration with peers, e.g., playing doctor, yes or
12 no?

13 MS. BROWN: Same objection.

14 THE WITNESS: Yes.

15 BY MR. HILDABRAND:

16 Q. On the right --

17 MS. BROWN: Are you finished? So before
18 your next question, I'm going to -- as long as you
19 continue this line of questioning, I'm going to
20 raise a standing objection to scope as we're talking
21 about sexuality here. And, again, for the record, I
22 believe you're conflating sexuality with gender
23 identity and that's going to be my standing
24 objection and I'll continue to make objections. You
25 may proceed.

1 MR. HILDABRAND: Yes. I believe we
2 agreed to do form objections in this case and not --
3 I understand you're trying to explain your position
4 but you've talked a lot in the past half hour.
5 That's not how we've been conducting these
6 depositions. And that may be your perspective on
7 the scope of it, but she is testifying as a
8 psychologist and has talked about sexual issues
9 throughout her report.

10 So I think that's why we are asking
11 these questions today and that's something we can
12 work out later. But for now, please, if you want to
13 object to form whenever you would like.

14 BY MR. HILDABRAND:

15 Q. On the right --

16 MS. BROWN: Yes.

17 MR. HILDABRAND: So on the right -- all
18 right. Let's turn to -- Travis, can you circulate
19 Doc E.

20 THE WITNESS: I think we're getting a
21 new document.

22 MS. BROWN: We have the document open.
23 But, again, for the record, a standing objection to
24 the extent Mr. Hildabrand is questioning the witness
25 about collective slides from what appear to be

1 larger presentations. You may proceed. We have D
2 open.

3 MR. HILDABRAND: And we're glad to
4 circulate the -- and, actually, I'll circulate the
5 YouTube link right now if that's what you'd like.
6 And in a minute we will enter the entire video as an
7 exhibit.

8 MS. BROWN: This is your time. If you'd
9 like to do that, that's fine. I just noted my
10 objection.

11 MR. HILDABRAND: That's great.

12 BY MR. HILDABRAND:

13 Q. All right. On this document -- so do you see
14 I circulated a link to a YouTube page? All right.

15 A. Yes. We see that in the chat.

16 Q. Thank you.

17 A. But we have not opened the link to confirm.

18 Q. Okay. Can you pull up Doc E? Are you
19 looking at that now? All right. On Doc E, is that,
20 again, you on the right?

21 A. Yes, this is me in Doc E.

22 Q. And is there a slide show presentation on the
23 left?

24 A. There is.

25 Q. Are there, again, columns labeled stage of

1 development, common behavior, and caregiver tasks?

2 A. Yes. They are columns which reflect tables
3 from the source about sexual development.

4 Q. Is it your understanding that sexual
5 development, is that relevant to the report that you
6 are providing in this case?

7 A. The report that I provided was within the
8 scope of gender identity and gender dysphoria in
9 individuals who identify as transgender in their
10 treatment, including the treatment guidelines.
11 Sexual development is an important part of childhood
12 development but it's distinct from an individual's
13 gender identity.

14 Q. So sexual development is not relevant to your
15 report on gender identity; is that correct?

16 MS. BROWN: Objection to form.

17 THE WITNESS: Sexual development and
18 gender identity, even say sex identity or sexuality
19 are distinct concepts.

20 BY MR. HILDABRAND:

21 Q. So yes or no, sexual development is not
22 relevant to your expert report?

23 MS. BROWN: Same objection.

24 THE WITNESS: Again, I would like to
25 make clear that sexual development and identity are

1 different than gender identity. So I'm not sure how
2 to answer your question with that.

3 BY MR. HILDABRAND:

4 Q. So you can't give -- you can't say that this
5 is not sexual -- you cannot say that sexual
6 development is not relevant to your report?

7 MS. BROWN: Same objection.

8 THE WITNESS: Sexual development is an
9 important part of childhood development and to the
10 scope that, you know, I can provide expert
11 information about child and adolescent development.

12 BY MR. HILDABRAND:

13 Q. But you cannot provide a yes or no answer to
14 that question?

15 MS. BROWN: Same objection.

16 THE WITNESS: I'm sorry, I don't mean to
17 be obstinate. I just -- I'm not sure how to answer
18 the question because they're different concepts.

19 BY MR. HILDABRAND:

20 Q. Okay. That's fair. Let's ask a few
21 questions about this and then we'll go out to lunch
22 at that point.

23 A. Okay.

24 Q. So here is the stage of development listed
25 middle childhood, age five to eight?

1 A. Yes.

2 Q. And in the common behavior column, does it
3 say may start showing interest in opposite sex?

4 A. Yes.

5 Q. And you used the phrase "opposite sex" here,
6 correct?

7 A. Yes.

8 Q. Then the slide says, common behavior includes
9 masturbation for pleasure, increasingly in private.
10 Is that what you said here?

11 A. Citing the source that's listed at the bottom
12 of the slide; however, that information is listed on
13 the slide.

14 Q. Would you agree that masturbation for
15 pleasure, increasingly in private, is common
16 behavior for five- to eight-year-olds?

17 MS. BROWN: Objection to form.

18 THE WITNESS: Masturbating for pleasure,
19 increasingly in private, is listed as a common
20 behavior and supported in the literature as a common
21 behavior in childhood.

22 BY MR. HILDABRAND:

23 Q. Thank you. On the right lists caregiver
24 tasks. Do you see where it says: Promote
25 understanding of gender and how children experience

1 their identity? Is that what you said on the first
2 bullet?

3 A. Again, this is citing a particular source.
4 Then we would -- we could verify within that source
5 that is what's listed on the slide to promote
6 understanding of gender and how children experience
7 their identity.

8 Q. So in your opinion, is that an appropriate
9 caregiver task to help five-to eight-year-olds
10 understand gender and how they experience their
11 gender?

12 A. I think this is a caregiver task across
13 development in childhood and adolescence, that
14 children, adolescents, and young adults can be
15 supported in understanding concepts about themselves
16 in the world around them, including gender.

17 Q. Including at ages five through eight,
18 correct?

19 MS. BROWN: Objection.

20 THE WITNESS: Yes. Ages five through
21 eight in and across development.

22 BY MR. HILDABRAND:

23 Q. Does it also say on the right that a
24 caregiver task is to explain basics of reproduction,
25 including vaginal intercourse? Is that what the

1 slide says in the second bullet?

2 MS. BROWN: Sorry, I did not mean to
3 interrupt you. Again, I'm going to note my
4 objection. Clark, I understand but I'm going to say
5 it again. I'm objecting to scope for all of these
6 questions and I'm going to continue.

7 MR. HILDABRAND: Yes. Just object to
8 form, as was agreed by both parties before the
9 deposition. So I'll repeat my question.

10 BY MR. HILDABRAND:

11 Q. On the right-hand side, does it say: Explain
12 basics of reproduction, including vaginal
13 intercourse? Is that in the caregiver task column?

14 MS. BROWN: Same objection.

15 THE WITNESS: That is listed in the
16 caregiver task column in this image.

17 BY MR. HILDABRAND:

18 Q. Do you agree today that this is an
19 appropriate caregiver task for children ages five
20 through eight?

21 MS. BROWN: Same objection.

22 THE WITNESS: Yes. It is an important
23 task for caregivers to provide information and
24 explain basics of reproduction to children.

25 / /

1 BY MR. HILDABRAND:

2 Q. Farther down that column, do you say: As a
3 caregiver task, explain differences in sexual
4 orientations? Is that an appropriate caregiver task
5 for children ages five through eight?

6 MS. BROWN: Same objection.

7 THE WITNESS: Yes.

8 BY MR. HILDABRAND:

9 Q. And then, finally, is there also listed in
10 the caregiver task column for children ages five
11 through eight, teach that masturbation is something
12 that occurs in private; is that listed?

13 MS. BROWN: Same objection.

14 THE WITNESS: It is listed.

15 BY MR. HILDABRAND:

16 Q. Is that an appropriate caregiver task for
17 children ages five through eight?

18 MS. BROWN: Same objection.

19 THE WITNESS: It is appropriate within
20 the family's value system and is an important part
21 of an individual's development.

22 BY MR. HILDABRAND:

23 Q. Is the family's value system referenced on
24 this slide?

25 A. On this particular slide, it is not

1 referenced; however, it was several slides
2 previously and within the context of this
3 presentation, if I recall correctly.

4 MR. HILDABRAND: Thank you. That's the
5 logical end point for questions right now if y'all
6 want to break for lunch.

7 MS. BROWN: Before that, quickly, if
8 you'll give me one moment before we go off the
9 record.

10 MR. HILDABRAND: Before we go off the
11 record, I'll enter collectively as Exhibit 3. This
12 presentation will be Exhibit 3.

13 (WHEREUPON, documents were marked as
14 Collective Exhibit Number 3.)

15 MS. BROWN: When you say presentation,
16 are you speaking about the YouTube link you
17 inserted?

18 MR. HILDABRAND: Yes. This entire
19 presentation will be Exhibit 3. And these clips are
20 from that presentation, so this is collectively
21 Exhibit 3. If you'd like me to, I can enter the
22 clips as a separate exhibit if that's what you'd
23 prefer but that's how we -- is that fine with you?

24 MS. BROWN: I'm requesting that all the
25 presentations be separately entered in as exhibits.

1 MR. HILDABRAND: All right. So we'll
2 enter the screenshots collectively as Exhibit 3.
3 The presentation will be Exhibit 4. If that's the
4 case, let's go and pull up this presentation. If
5 you can click the YouTube link in there just so we
6 can establish that this is the presentation.

7 (WHEREUPON, a document was designated to
8 be marked as Late-filed Exhibit Number 4, when
9 provided.)

10 MS. BROWN: Okay. We have the
11 presentation playing.

12 MR. HILDABRAND: Great. So on the first
13 page, do you see -- I'm sorry. Let's play a little
14 bit. At point -- at the first second of the video,
15 if you can go there?

16 MS. BROWN: Sorry, the second?

17 MR. HILDABRAND: Yes. 0:01 of the
18 presentation. Just go there.

19 MS. BROWN: Okay.

20 BY MR. HILDABRAND:

21 Q. Do you see -- Dr. Cyperski, do you see
22 yourself in the upper right corner of this video?

23 A. Yes.

24 Q. And is there a slide show presentation on the
25 left that says: Sexual behavior problems toward

1 health and healing for children, adolescents, and
2 their families; is that correct?

3 A. Yes.

4 Q. All right. Now let's go to 239. Just go
5 there. We don't need to watch it.

6 Is that the same slide that we discussed as
7 Doc C?

8 A. It appears so, yes. If I could, like to
9 request to take a break soon.

10 Q. Yes. I'm just going to go and just confirm
11 for the other two and then take a break at that
12 point.

13 A. Okay.

14 Q. I know we wanted to end at noon but I just
15 wanted to -- so we don't have to go back and confirm
16 each of these.

17 Let's go now to 3:52 in the video. I'm
18 sorry. This one is -- sorry 5:52 in the video. At
19 5:52 in the video, do you see a slide that lists
20 stage of development, common behavior, and caregiver
21 tasks?

22 A. So early childhood age two through five, yes.

23 Q. Yes. And is that the same slide that we
24 discussed earlier as Doc D?

25 A. Yes.

1 Q. All right. Last time, let's go to I think
2 it's seven minutes into the video. Is that the same
3 slide that we discussed as Doc E?

4 A. It appears that way.

5 MR. HILDABRAND: That's all that I have
6 if y'all want to take a break now.

7 MS. BROWN: Okay. I need to say -- we
8 can go off the record.

9 (Recess observed.)

10 MR. HILDABRAND: Let's go back on the
11 record. All right. Now that we are back on the
12 record, I have that we've spent two hours and 20
13 minutes so far in the deposition. Now that we are
14 back, I just want to note, we discussed this off the
15 record a little bit, but my understanding is under
16 the Federal Rules of Civil Procedure 30(c)(2) is
17 that an objection must be stated concisely in a
18 non-argumentative and non-suggestive manner. If
19 there is a concern about speaking objections and
20 coaching, I will put that on the record, that's
21 fine, and we reserve the right to request from the
22 court any further action that we deem necessary to
23 make sure that our deposition is carried out. All
24 right. To restart.

25 BY MR. HILDABRAND:

1 Q. Is the mental health of children relevant to
2 your report?

3 MR. ROYER: Clark, hold on one second.
4 Their mic is still activating.

5 MR. HILDABRAND: Oh.

6 MS. BROWN: Okay. We're back.

7 BY MR. HILDABRAND:

8 Q. Great. Is the mental health of children
9 relevant to your report?

10 A. Yes.

11 Q. Is the psychological development of children
12 relevant to your report?

13 A. Yes.

14 Q. Is a child's experience of identity relevant
15 to your report?

16 A. Yes.

17 Q. Are the changes that occur during puberty
18 relevant to your report?

19 MS. BROWN: Objection.

20 THE WITNESS: The changes that occur
21 during puberty may be considered in part of a
22 gender-affirming process.

23 BY MR. HILDABRAND:

24 Q. All right. Is instruction of children about
25 sex relevant to your report?

1 MS. BROWN: Objection to form.

2 THE WITNESS: Can you say what you mean?

3 BY MR. HILDABRAND:

4 Q. Is instructing children about sexual acts
5 relevant to your report?

6 MS. BROWN: Objection to form again.

7 THE WITNESS: What does instructing
8 children about sexual acts mean?

9 BY MR. HILDABRAND:

10 Q. Is teaching children about sexual acts
11 relevant to your report?

12 MS. BROWN: Same objection.

13 THE WITNESS: Not that I'm aware.
14 Although talking about sexual identity and an
15 individual's sense of identity may be.

16 BY MR. HILDABRAND:

17 Q. Is sex as a noun to refer to someone's sex,
18 is that relevant to your report?

19 MS. BROWN: Objection to form.

20 THE WITNESS: Again, what do you mean by
21 sex in this context?

22 BY MR. HILDABRAND:

23 Q. Not necessarily how I understand it but is
24 sex assigned at birth relevant to your report?

25 A. Yes.

1 Q. Is the privacy of children a relevant
2 consideration for your report?

3 MS. BROWN: Objection to form.

4 THE WITNESS: What do you mean by
5 privacy?

6 BY MR. HILDABRAND:

7 Q. Is the privacy of children in exposing or not
8 exposing their genitalia a relevant consideration in
9 your report?

10 MS. BROWN: Objection to form.

11 THE WITNESS: Discussing whether a child
12 is exposing their genitalia to others is not
13 relevant.

14 BY MR. HILDABRAND:

15 Q. Can we turn to paragraph 26 in your report.
16 That's Doc A, Exhibit 1, at the bottom of page
17 seven, going on to the top of page eight.

18 MS. BROWN: I'm sorry, can you provide
19 me with the page number again?

20 MR. HILDABRAND: Of course. Bottom of
21 page seven, top of page eight. The paragraph goes
22 on to both.

23 THE WITNESS: Okay. We're on the bottom
24 of page seven.

25 / /

1 BY MR. HILDABRAND:

2 Q. You say there that maintaining privacy about
3 one's transgender identity can be important to
4 safety given the persistence of harassment and even
5 violence exhibited against transgender people.

6 A. Yes.

7 Q. So is maintaining privacy relevant to your
8 report?

9 MS. BROWN: Objection to form.

10 THE WITNESS: It may be helpful to know
11 in what specific context we're talking about
12 maintaining privacy as the reports states
13 maintaining privacy about one's identity can be
14 important to their safety.

15 BY MR. HILDABRAND:

16 Q. How do you understand the term "privacy" that
17 you used here? What's your understanding of that?

18 MS. BROWN: Objection to form.

19 THE WITNESS: My interpretation is
20 privacy representing confidentiality.

21 BY MR. HILDABRAND:

22 Q. What sort of confidentiality are you talking
23 about?

24 MS. BROWN: Objection to form.

25 THE WITNESS: Is the question about in

1 the report?

2 BY MR. HILDABRAND:

3 Q. You just used the word "confidentiality". In
4 your answer that you gave, what do you mean by
5 confidentiality?

6 A. I was providing an answer about the
7 definition of privacy. So in this sentence in the
8 report might be that maintaining confidentiality
9 about one's identity could be important to safety.

10 Q. So not having other people know that one is
11 transgender could be relevant to privacy?

12 MS. BROWN: Objection to form.

13 THE WITNESS: Maintaining
14 confidentiality about their identity can be
15 important to safety and that would include about
16 their gender identity.

17 BY MR. HILDABRAND:

18 Q. Thank you. Is the understanding of gender
19 identity among psychologists still developing?

20 MS. BROWN: Objection to form.

21 THE WITNESS: I'm not sure what you mean
22 still developing.

23 BY MR. HILDABRAND:

24 Q. Are there still aspects of gender identity
25 that psychologists disagree about?

1 MS. BROWN: Objection to form.

2 THE WITNESS: It's common in medical and
3 scientific fields for the literature or terminology
4 to continue to be evolving with new study and
5 evidence and in that way it is possible that things
6 are still evolving.

7 BY MR. HILDABRAND:

8 Q. Is this a rapidly evolving field?

9 MS. BROWN: Objection to form.

10 THE WITNESS: What do you mean by
11 rapidly?

12 BY MR. HILDABRAND:

13 Q. We can come back to that in a minute. Is
14 there much data on the mental health in transgender
15 children?

16 MS. BROWN: Objection to form.

17 THE WITNESS: There is a significant
18 body of evidence about mental health in transgender
19 children.

20 BY MR. HILDABRAND:

21 Q. Are most of the studies on transgender mental
22 health based on small sample sizes?

23 MS. BROWN: Objection to form.

24 THE WITNESS: I would need to see
25 specific numbers of sample sizes that you referenced

1 and this would be specific to each article.

2 BY MR. HILDABRAND:

3 Q. That's fair. In general, are larger sample
4 sizes preferred to smaller sample sizes?

5 MS. BROWN: Objection to form.

6 THE WITNESS: In the mental health
7 literature, we often have peer-review publications
8 that include single case studies or small case
9 studies, ranging all the way from one individual up
10 to large sample sizes. Thousands of people.

11 BY MR. HILDABRAND:

12 Q. Everything else being equal, would you prefer
13 a study that had one individual case or a study that
14 had multiple cases considered?

15 MS. BROWN: Again, objection to form.

16 THE WITNESS: It would depend on the
17 purpose of the literature and the article I was
18 reviewing.

19 BY MR. HILDABRAND:

20 Q. Is the study more likely to be statistically
21 valid if it has a larger sample size or a smaller
22 sample size?

23 MS. BROWN: Objection to form.

24 THE WITNESS: Here there may be some
25 nuances about statistical analysis that would be

1 important to review with a statistician. It's very
2 likely that in large sample sizes, for example, it's
3 easy to find significant differences that have
4 little meaning because there are so many people we
5 can find information. If we're looking at hundreds
6 of thousands of people, that would be significant.

7 BY MR. HILDABRAND:

8 Q. Thank you. Let's go to PDF page 13. Page
9 two of your -- sorry -- page three of your CV if you
10 want to scroll down to that. This is back in Doc A,
11 Exhibit 1, your report.

12 MS. BROWN: Sorry, Clark, page two of
13 the CV?

14 MR. HILDABRAND: Just one second. Page
15 three of your CV.

16 THE WITNESS: Okay. We're there.

17 BY MR. HILDABRAND:

18 Q. Do you see under continuing medical education
19 an October of 2020 presentation?

20 A. Yes.

21 Q. What's the title of that presentation listed
22 there?

23 A. Path to Affirmative Medical Care for
24 Transgender/Gender Diverse Youth: A Guide for
25 Mental Health Provider.

1 Q. All right. I'm going to circulate the
2 recording of that in just one second.

3 MR. HILDABRAND: This will be Doc F, and
4 we'll enter this as Exhibit 5. This will be 5.

5 (WHEREUPON, a document was designated to
6 be marked as Late-filed Exhibit Number 5, when
7 provided.)

8 BY MR. HILDABRAND:

9 Q. Do you have that pulled up?

10 A. Yes.

11 Q. Feel free to go ahead to around the 22 second
12 mark, 0:22. When you're there, does it say: Path
13 to Affirmative Medical Care for Transgender/Gender
14 Diverse (TGD Youth): A Guide for Mental Health
15 Providers?

16 A. It does.

17 Q. And is your name listed there at the top?

18 A. It is.

19 Q. Does this appear to be the presentation that
20 you gave back in October of 2020?

21 A. Yes.

22 Q. Okay. Now let's turn to the -- jumping ahead
23 to the 58:22 second mark. 58:22. And if you can,
24 please listen to 58:22 to 58:50. And when you do
25 that, just let me know.

1 MS. BROWN: Clark, we're actually not
2 getting the audio from this video and I'm sure it's
3 a tech situation on our end. So do you want to go
4 off the record for like five minutes so I can figure
5 out how to get the audio to play? Or is there
6 audio? I'm not hearing anything.

7 MR. HILDABRAND: Yes. There is audio.
8 So if you want to go off the record for a minute we
9 can sort that out. All right. Let's go off the
10 record.

11 MS. BROWN: We're ready.

12 BY MR. HILDABRAND:

13 Q. All right. We are now back on the record.
14 Before we get to the video, I'm going to read out
15 first the website address of what was entered as
16 Exhibit 4 and what the cumulative Exhibit 3 slides
17 were taken from. That is
18 <https://www.YouTube.com/watch?v=322u6en50d8>. And
19 then I will say the website address for what has
20 been marked Exhibit 5. That is
21 <https://www.YouTube.com/watch?v=HvLYai7qq0A>. All
22 right. And now --

23 MS. BROWN: Oh, sorry, I didn't want to
24 interrupt. I just wanted to flag Britany on our
25 team, you're not on mute and I saw the audio switch

1 to you. Okay. Thanks. You got it. Thanks.

2 MR. HILDABRAND: Thanks for making sure.
3 And now the witness is going to click play around
4 the 58:20 or 58:22 mark of the video and listen to
5 58:50.

6 THE WITNESS: Okay. Pressing play.
7 (Playing video.)

8 Our best practices are still emerging
9 for children and adolescents. This is, you know --
10 what we know about therapy and mental health is done
11 through relatively small case studies at this point
12 in time but the literature is growing every day. We
13 look a lot to the principles of trauma-informed care
14 to be supportive and so leading with the
15 individual's affirmation believing their truth and
16 helping them to identify where the distress and the
17 hurt is. I think --

18 (Stopped video.)

19 MS. BROWN: Okay. That's at 58:51.
20 You're on mute again. Sorry.

21 BY MR. HILDABRAND:

22 Q. Yeah. Dr. Cyperski, was that you speaking?

23 A. That was me speaking as part of a one-hour
24 presentation.

25 Q. Did you say that our best practices are still

1 emerging for children adolescents?

2 MS. BROWN: If you want to hear it
3 again, it was playing very quickly, to confirm, we
4 can do that.

5 THE WITNESS: Uh-huh. Uh-huh.

6 MS. BROWN: And I'm sorry. Will you
7 just repeat the question and then we'll try to
8 confirm?

9 BY MR. HILDABRAND:

10 Q. Sure. Yes. This question is, Our best
11 practices are still emerging for children and
12 adolescents, did you say that?

13 (Playing video.)

14 Our best practices are still emerging
15 for children and adolescents. This is, you know,
16 what we know about --

17 (Stopped video.)

18 BY MR. HILDABRAND:

19 Q. Right. So did you say that statement?

20 A. That statement was said again as part of
21 context within a one-hour presentation.

22 Q. Do you agree that the best practices for
23 psychological treatment of transgender children are
24 still emerging?

25 MS. BROWN: Objection to form.

1 THE WITNESS: So this particular
2 statement would need to be understood in context and
3 I believe at this point in the presentation we were
4 answering Q&A. And so would be preferable to review
5 some more of the contents before and after that
6 statement to inform interpretation.

7 BY MR. HILDABRAND:

8 Q. Rather than watching the whole -- the entire
9 video, which glad at any point if you -- glad after
10 the deposition if you want to review that or during
11 a break. But would you agree with the statement
12 today that best practices are still emerging for
13 children and adolescents regarding transgender
14 healthcare?

15 MS. BROWN: Objection to form.

16 THE WITNESS: So the question is if best
17 practices are still emerging -- can you repeat it?
18 I'm so sorry.

19 BY MR. HILDABRAND:

20 Q. Are best practices for transgender children,
21 treating them for mental health, still emerging?

22 MS. BROWN: Same objection.

23 THE WITNESS: We have many established
24 best practice guidelines such as the Endocrine
25 Society and the WPATH. As previously provided in an

1 answer a few minutes ago, in all of medical sciences
2 we are regularly updating the literature and
3 exploring new information to keep our practice
4 current in support of best practices.

5 BY MR. HILDABRAND:

6 Q. Did you also say that what we know about
7 therapy and mental health is done through relatively
8 small case studies at this point in time? And if
9 you want to watch the video, that's fine.

10 A. Okay. We're going to pull up the video
11 again.

12 MS. BROWN: Clark, do you have a time
13 stamp? I know it's relatively short but...

14 MR. HILDABRAND: And you can start at
15 5:24. I'll be after that statement, the statement
16 we discussed a minute ago.

17 MS. BROWN: 58:25.

18 THE WITNESS: Okay. Hitting play.

19 MS. BROWN: Oh, wait. And just to make
20 sure, Clark, will you repeat the question?

21 BY MR. HILDABRAND:

22 Q. Did you say that what we know about therapy
23 and mental health is done through relatively small
24 case studies at this point in time?

25 (Playing video.)

1 What we know about therapy and mental
2 health is done through relatively small case studies
3 at this point in time.

4 (Stopped video.)

5 THE WITNESS: Yes. Again, that
6 statement was made in context of a larger discussion
7 in a one-hour presentation and is a very small
8 snippet of which may wish to more accurately
9 describe and articulate in another context.

10 BY MR. HILDABRAND:

11 Q. So at this point in time, two years later,
12 would you agree that what we know about therapy and
13 mental health is done through relatively small case
14 studies at this point in time? And feel free to
15 elaborate or provide further context.

16 MS. BROWN: Objection to form.

17 THE WITNESS: What we know about mental
18 health in the transgender population is that there
19 is a significant body of literature that identifies
20 mental health concerns and experience in transgender
21 children and we are ongoing working to update and
22 advance the literature in the state of the science
23 as is consistent with best practices across medicine
24 and other professions.

25 / /

1 BY MR. HILDABRAND:

2 Q. Are those developments done through
3 relatively small case studies at this point in time
4 today?

5 MS. BROWN: Objection to form.

6 THE WITNESS: I would be curious what
7 you mean and what the definition of relatively small
8 case studies would be.

9 BY MR. HILDABRAND:

10 Q. How would you understand that phrase,
11 "relatively small case studies"? Do you have an
12 understanding of what that would mean?

13 MS. BROWN: Same objection.

14 THE WITNESS: I can see several
15 different interpretations of what relatively small
16 case studies would mean.

17 BY MR. HILDABRAND:

18 Q. What are some of those interpretations?

19 A. If someone were using that phrase, it might
20 mean that there were a small number, so a handful of
21 case studies. It might mean that there were case
22 studies which included a small number of
23 participants would be another interpretation.

24 Q. In your practice, do you begin by believing
25 the individual's truth about their gender identity?

1 MS. BROWN: Objection to form.

2 THE WITNESS: Can you repeat the
3 question?

4 BY MR. HILDABRAND:

5 Q. Of course. In your practice treating
6 transgender individuals, do you begin by believing
7 their truth about what they express their gender
8 identity to be?

9 MS. BROWN: Same objection.

10 THE WITNESS: It might be important to
11 define believing their truth and the statement could
12 be considered in the context of gender-affirming
13 care.

14 BY MR. HILDABRAND:

15 Q. Are some children incorrect about what their
16 gender identity is?

17 MS. BROWN: Objection to form.

18 THE WITNESS: No.

19 BY MR. HILDABRAND:

20 Q. So all children know what their gender
21 identity is; is that your position?

22 MS. BROWN: Objection to form.

23 THE WITNESS: By definition that we
24 established previously, individual gender identity
25 is their own sense of self of their internal sense

1 of gender. So I'm having a hard time thinking
2 through when an individual's declaration of their
3 gender identity would ever be incorrect because it
4 is their own understanding of their gender.

5 Q. Thank you. That's helpful. Let's go to your
6 report, paragraph 14, which is on page four.

7 A. Okay. Page four of the report.
8 Paragraph 14?

9 Q. Yes.

10 A. We are there.

11 Q. Great. Does it say that many transgender
12 people become aware of their gender identity at a
13 very early age? Is that what the report says?

14 A. That is in the report.

15 Q. Do you still agree with that statement today?

16 A. Yes.

17 Q. You used the phrase "at a very early age."
18 What ages do you mean by that phrase here?

19 A. In the literature, there is evidence that
20 children and people can start to become aware of
21 their gender as young as three years old or younger.
22 It is going to vary by individual and by their
23 unique abilities.

24 Q. What is the youngest a patient has told you
25 that they are transgender?

1 MS. BROWN: Objection to form.

2 THE WITNESS: In my clinical experience,
3 I have heard patients and their caregivers recount
4 that they first became aware and shared their gender
5 identity at the age of two or three.

6 BY MR. HILDABRAND:

7 Q. Just to clarify, is that a transgender
8 identity they shared at the age of two or three?

9 MS. BROWN: Objection to form.

10 THE WITNESS: Can you restate the
11 question for me, please?

12 BY MR. HILDABRAND:

13 Q. Glad to. So are you aware of children ages
14 two to three expressing a gender identity
15 inconsistent with their sex assigned at birth?

16 A. Yes.

17 Q. Have children at the ages of two to three who
18 have expressed a gender identity inconsistent with
19 their sex assigned at birth been treated at VPATH?

20 MS. BROWN: Objection to form.

21 THE WITNESS: Within the VPATH Clinic, I
22 am not aware of the specific age range for all of
23 the patients seen by all of the providers in our
24 clinic. So I don't know that I am aware of how to
25 answer that question at this point.

1 BY MR. HILDABRAND:

2 Q. What's the youngest age child who expressed a
3 gender identity inconsistent with their sex assigned
4 at birth that you are aware being treated at VPATH?

5 MS. BROWN: Same objection.

6 THE WITNESS: I am aware of children who
7 are probably six years old that have been -- who
8 have met with one of the providers in our
9 interdisciplinary clinic.

10 BY MR. HILDABRAND:

11 Q. Are you aware of children at ages five or
12 younger who have met with professionals at VPATH?

13 A. It is certainly possible that children under
14 six years old could meet with one of the
15 professionals.

16 Q. But today you're not aware one way or the
17 other?

18 A. I am not.

19 Q. All right. Going back to Exhibit 5, the
20 YouTube video. Actually, before we do that, what
21 percentage of children persist in their expressed
22 transgender identity?

23 MS. BROWN: Objection to form.

24 THE WITNESS: We would need some
25 additional context to answer that question.

1 BY MR. HILDABRAND:

2 Q. What's your estimation of the percentage of
3 children that persist in their gender identity? And
4 feel free to break it out if you want to between
5 prepubertal children or children in the middle of
6 puberty or children are teenagers who have completed
7 puberty?

8 MS. BROWN: Same objection.

9 THE WITNESS: So the question is around
10 individuals who persist in their gender identity.
11 And there is a high percentage of individuals,
12 children and adolescents who, upon sharing and
13 discovering their gender identity, will persist in
14 their identity.

15 BY MR. HILDABRAND:

16 Q. Let's go in the video, Exhibit 5, to the
17 12:15 mark. We're not going to listen to anything
18 here. We're just going to just look at the screen
19 if you can see that.

20 MS. BROWN: I'm sorry, Clark. What's
21 the title of the video?

22 MR. HILDABRAND: Oh. This is the more
23 recent one, the Path to Affirmative Medical Care for
24 Transgender/Gender Diverse Youth.

25 MS. BROWN: So are we done with audio?

1 MR. HILDABRAND: Don't need the audio.

2 MS. BROWN: Okay. Well, we have it
3 pulled up.

4 BY MR. HILDABRAND:

5 Q. In about the 12:15, 12:20 mark, the slide
6 there.

7 MS. BROWN: Okay. We're at 12:16.

8 BY MR. HILDABRAND:

9 Q. Does this slide say considerations for youth?

10 A. Yes.

11 Q. Then does it say validity in prepubertal
12 children versus adolescents?

13 A. It does.

14 Q. What percentage does it give for how children
15 persist?

16 A. On this slide from, I believe it was a
17 presentation in 2020, it says: Fluidity in
18 prepubertal children versus adolescents and the
19 first bullet point is children persist 12 to
20 27 percent.

21 Q. And just to be fair with you earlier, in the
22 bottom right-hand side corner, is there anything
23 that it looks like the slide is citing?

24 A. Yes, sir. There are several articles that
25 are cited on this slide.

1 Q. And then going back up, does it say that
2 adolescents near 100 percent persistence?

3 A. It does.

4 Q. In your experience as a psychologist, is it
5 12 to 27 percent persistence, do you find that
6 accurate for children?

7 MS. BROWN: Objection to form.

8 THE WITNESS: In my professional
9 practice, I find this number is significantly lower
10 than what I have experienced in practice.

11 BY MR. HILDABRAND:

12 Q. And then for the adolescents near 100 percent
13 persistence, is that accurate with what you've found
14 in your practice?

15 MS. BROWN: Same objection.

16 THE WITNESS: In my professional
17 practice adolescents have 100 percent persistence.

18 BY MR. HILDABRAND:

19 Q. Are you aware of any academic studies done of
20 individuals who have desisted from an express
21 transgender gender identity?

22 MS. BROWN: Objection to form.

23 THE WITNESS: Define what you mean by
24 academic studies in this case.

25 / /

1 BY MR. HILDABRAND:

2 Q. A peer-reviewed journal article, for example.

3 A. And the question was a peer-reviewed journal
4 article about what?

5 Q. A peer-reviewed journal article about
6 individuals who previously expressed that their
7 gender identity was inconsistent with their sex
8 assigned at birth but later expressed that they were
9 incorrect and that their gender identity really was
10 consistent with their sex assigned at birth?

11 MS. BROWN: Objection to form.

12 THE WITNESS: There has been
13 peer-reviewed studies on a number of topics,
14 including individuals' persistence of gender
15 identity.

16 MR. HILDABRAND: Travis, can you go
17 ahead and circulate Document K.

18 THE WITNESS: We have that open.

19 BY MR. HILDABRAND:

20 Q. And what is the title of this article?

21 A. It reads: Individuals Treated for Gender
22 Dysphoria with Medical and/or Surgical Transition
23 who Subsequently Detransitioned, A Survey of 100
24 Detransitioners by Lisa Littman.

25 Q. And what journal does this appear to be

1 published in? And --

2 A. This is published -- I'm sorry. Go ahead.

3 Q. I'm sorry, just for help, toward the top
4 would be somewhere to look. But if you want to
5 answer.

6 A. Yes. It's published in the, appears, in The
7 Archives of Sexual Behavior, 2021.

8 Q. Is that a reputable journal?

9 MS. BROWN: Objection to form.

10 BY MR. HILDABRAND:

11 Q. In your professional experience, is this the
12 sort of journal whose articles you might rely upon?

13 A. I am not familiar with the specifics of this
14 journal. And it appears to be a publication from
15 that journal, however.

16 Q. Have you read this article or heard about it
17 before?

18 MS. BROWN: Objection to form.

19 THE WITNESS: I have read this article
20 in the past.

21 BY MR. HILDABRAND:

22 Q. Do you remember what your impression of the
23 article was when you read it?

24 MS. BROWN: Objection to form.

25 THE WITNESS: Is the question about when

1 I initially read the article?

2 BY MR. HILDABRAND:

3 Q. What's your -- do you have an opinion about
4 this article?

5 MS. BROWN: Objection to form.

6 THE WITNESS: I would need to review the
7 article again. It has been sometime since I last
8 read this article.

9 BY MR. HILDABRAND:

10 Q. All right. So let's go through parts of this
11 article and discuss.

12 A. Okay.

13 Q. I'll point you to parts of it in just one
14 second.

15 MS. BROWN: Is it zoomed in enough for
16 you?

17 THE WITNESS: Yeah, I can see it. Thank
18 you.

19 BY MR. HILDABRAND:

20 Q. So under introduction, do you see the first
21 line? Can you read that out?

22 A. Uh-huh. Detransition is the act of stopping
23 or reversing a gender transition.

24 Q. Do you agree that that is a fair definition
25 of the word "detransition" in this field?

1 MS. BROWN: Objection to form.

2 THE WITNESS: This is a definition of
3 detransition and our field uses other terms to
4 describe this phenomenon as well.

5 BY MR. HILDABRAND:

6 Q. What terms would you use to describe this
7 phenomenon?

8 A. One common term that's been identified in the
9 field is also retransition.

10 Q. Is detransition a term that others in your
11 field use to describe this?

12 MS. BROWN: Objection to form.

13 THE WITNESS: Some professionals use the
14 term "detransition".

15 BY MR. HILDABRAND:

16 Q. How many of your patients have ever
17 detransitioned or retransitioned?

18 MS. BROWN: Objection to form.

19 THE WITNESS: We would need to define
20 those terms of detransition or retransition to
21 answer that question.

22 BY MR. HILDABRAND:

23 Q. How many of your -- how many of the
24 individuals you have treated in your practice have
25 stopped or reversed a gender transition?

1 MS. BROWN: Objection to form.

2 THE WITNESS: None of my patients have
3 ever stopped or reversed a gender transition.

4 BY MR. HILDABRAND:

5 Q. Are you aware of any patients at VPATH who
6 have stopped or reversed a gender transition?

7 MS. BROWN: Objection to form.

8 THE WITNESS: I am aware of one case by
9 another provider in the Interdisciplinary Clinic of
10 an individual who identified as retransitioning.

11 BY MR. HILDABRAND:

12 Q. Can you give me any particulars you can
13 remember about that case without providing names of
14 the individual?

15 MS. BROWN: Objection to form.

16 THE WITNESS: Which particulars would
17 you be interested in?

18 BY MR. HILDABRAND:

19 Q. Sure. Have they been on puberty blockers at
20 any point in their treatment to the best of your
21 knowledge?

22 A. So the patient I am thinking of I did not
23 have contact with. And in fact I believe they may
24 have established care prior to the initiation of our
25 interdisciplinary clinic at VPATH with one of our

1 endocrinologists. So I'm not aware of many of the
2 details of their case.

3 Q. Which professional at VPATH would be aware of
4 the details of that case?

5 A. I believe it was a patient of Dr. Jennifer
6 Najjar, who is a pediatric endocrinologist.

7 Q. Thank you. If it's the case that that doctor
8 handled, I'll stop asking you questions about it.

9 Going back up to the abstract of this. Do
10 you see where it says that only 24 percent of
11 respondents informed their clinicians that they had
12 detransitioned?

13 A. I see that text in the abstract, yes.

14 Q. Do you mainly treat children and adolescents?

15 A. I work with children, adolescents, young
16 adults, and their caregivers.

17 Q. What's the age range of patients whom you
18 treat?

19 A. Are you asking about current caseload or in
20 my practice in general?

21 Q. We can ask current caseload first.

22 A. Okay. In my current caseload, I have
23 patients I would estimate who are seven to 22.

24 Q. Are most of your patients under the age of
25 18?

1 A. Many of my patients are under the age of 18.
2 I would agree that most are, yes.

3 BY MR. HILDABRAND:

4 Q. How long have you been licensed to practice
5 psychology in Tennessee?

6 A. I believe I have been licensed since 2017 in
7 the state of Tennessee.

8 Q. Any states prior to that where you were
9 licensed to practice psychology?

10 A. No. I was licensed as soon as I was
11 eligible.

12 Q. And so that's about five years; is that
13 correct?

14 A. Yes.

15 Q. So you have not been treating -- there is no
16 patient you have been treating -- I'm sorry.

17 Rephrase.

18 Are there any patients you are treating whom
19 you have been treating for more than five years?

20 A. I have some patients in my practice that I
21 have had a treatment relationship with since I would
22 say the start of my predoctoral internship or the
23 year of my predoctoral internship, which would be
24 2015 or 2016.

25 Q. So you have not been treating -- you do not

1 have any relationship with a patient who you been
2 treating that's lasted more than eight years; is
3 that correct?

4 A. That's correct.

5 Q. All right. So earlier you mentioned that you
6 wrote a thesis that was required to receive your
7 Master's of Science from Auburn University; is that
8 correct?

9 A. Yes.

10 MR. HILDABRAND: Travis, can you
11 circulate Document G. And we'll mark that as
12 Exhibit 6.

13 THE REPORTER: Did we mark Exhibit K?

14 MR. HILDABRAND: Oh, you're right. I
15 think that one should be marked Exhibit 6 and this
16 will be Exhibit 7.

17 (WHEREUPON, documents were marked as
18 Exhibit Numbers 6 and 7.)

19 BY MR. HILDABRAND:

20 Q. Just one second. All right. If you can see
21 that, what is the title of this document?

22 A. It says Examining Executive Functioning
23 Deficits in Juvenile Delinquents with a History of
24 Trauma Exposure.

25 Q. And who is the author?

1 A. Myself, Melissa Cyperski.

2 Q. Is this the thesis you submitted for your MS?

3 A. It appears that way. This is the title page.

4 We've not reviewed the full document.

5 Q. On the title page, does it say approved by
6 and lists three different professors?

7 A. Yes.

8 Q. All right. Let's turn to page 20 in the PDF.
9 This will be page 14 in the thesis pagination but
10 it'll be page 20 in the PDF.

11 A. Which page on the document? We're on page 20
12 of the PDF, but to confirm.

13 Q. Page 14 in the thesis's pagination.

14 A. Yes.

15 Q. Do you see -- in the first full paragraph, do
16 you see the line that says: Throughout their
17 lifetime, trauma survivors of both sexes experience
18 increased rates of new disturbance, anxiety,
19 disordered personality, maladaptive eating and
20 substance use, ADHD, and oppositional defiant
21 behavior?

22 A. I see that sentence in the document.

23 Q. In that sentence, did you use the phrase
24 "both sexes"?

25 A. In this document from 2012, I did use the

1 term "both sexes".

2 Q. Do you still use the phrase "both sexes"
3 today?

4 MS. BROWN: Objection to form.

5 THE WITNESS: I would not use the
6 terminology "both sexes" today.

7 BY MR. HILDABRAND:

8 Q. So you would not use the terminology today
9 that you used in your MS thesis ten years ago?

10 MS. BROWN: Objection to form.

11 THE WITNESS: I would use current
12 terminology and my understanding of the literature
13 and the state of our science in our field in my
14 practice today.

15 BY MR. HILDABRAND:

16 Q. So is both sexes not current terminology?

17 MS. BROWN: Objection to form.

18 THE WITNESS: It is not consistent with
19 my current practice.

20 BY MR. HILDABRAND:

21 Q. All right. Let's go back to your report.
22 This is Doc A, Exhibit 1. Let's go to -- it's page
23 21 in the PDF, page 11 in the CV.

24 A. Page 21 of the PDF and I believe that this is
25 11 of the CV. We are scrolling to confirm. Yes, we

1 are there.

2 Q. Does this list all the articles you have
3 published?

4 A. It does list peer-reviewed articles that I
5 have published, yes.

6 Q. Have you published any since submitting your
7 expert report?

8 A. No.

9 MR. HILDABRAND: All right. Do y'all
10 want to take a break here? We've been going for
11 about an hour since then, or do you want to keep
12 going?

13 MS. BROWN: We're happy to take a break.

14 MR. HILDABRAND: Okay. Let's go off the
15 record, then.

16 (Recess observed.)

17 MR. HILDABRAND: So I have about three
18 hours and 12 minutes on the record so far.

19 BY MR. HILDABRAND:

20 Q. So going back to your CV, we were just
21 discussing this list of articles. Is the first
22 article listed there titled: Disproportionate
23 minority contact: Comparisons across juveniles
24 adjudicated for sexual and non-sexual offenses? Is
25 that the article title?

1 A. Yes. Yes.

2 Q. Does it appear that the subject of this
3 article is the mental health of transgender
4 adolescents or children?

5 MS. BROWN: Objection to form.

6 THE WITNESS: So I would need to review
7 the specifics of that article.

8 BY MR. HILDABRAND:

9 Q. If you can't remember off of the top of your
10 head, that's fine. You can't just remember right
11 now that that's the subject of it?

12 A. The subject is related to the concept of
13 disproportionate minority contacts.

14 Q. So the second article is: Installing
15 trauma-informed care through the Tennessee Child
16 Protective Services Academy.

17 Do you remember -- and of course feel free to
18 say if you can't remember off the top of your head
19 right now -- whether or not that was related to the
20 subject of the mental health of transgender
21 adolescents or children?

22 A. That paper is not related to transgender
23 individuals.

24 Q. And then the third article is: Heterogeneity
25 in male adolescents with illegal sexual behaviors:

1 A latent profile approach to classification. Is
2 that the title of the article?

3 A. Yes.

4 Q. Do you recall whether or not the subject of
5 that article is the mental health of transgender
6 adolescents or children?

7 A. That article is not related to transgender
8 children or adolescents.

9 Q. And then the last article here is titled:
10 Supporting transgender/gender diverse (TGD) youth
11 across settings in systems of care: Experiences
12 from a pediatric interdisciplinary clinic. Is that
13 the title of the article?

14 A. It is.

15 Q. And that would be related to the subject of
16 the mental health in transgender adolescents or
17 children?

18 A. Correct.

19 MR. HILDABRAND: Travis, can you
20 circulate Document H. And we'll mark that as
21 Exhibit 8 I believe is the number we're on.

22 (WHEREUPON, a document was marked as
23 Exhibit Number 8.)

24 BY MR. HILDABRAND:

25 Q. Thank you. Dr. Cyperski, when you can see

1 that, what is the title of the article here?

2 A. We can see it. The title reads: Supporting
3 transgender/gender diverse youth across settings and
4 systems of care: Experiences from a pediatric
5 interdisciplinary clinic.

6 Q. Does this appear to be the fourth article
7 listed in your CV?

8 A. It does appear that way, yes.

9 Q. And who are the authors of this article?

10 A. Authors are Melissa Cyperski, along with
11 Drs. Mary Romano and Cassandra Brady.

12 Q. And do you work with Mary Romano and
13 Cassandra Brady at Vanderbilt University Medical
14 Center?

15 A. I do.

16 Q. If you can remember, what is the subject of
17 this? What is this article about?

18 A. From what I can recall, this article is about
19 ways to support transgender youth across various
20 settings and systems of care, so different ways that
21 youth, that providers can support youth in various
22 situations and settings in which they interact on a
23 daily basis.

24 Q. And was this a peer-reviewed article?

25 A. It was.

1 Q. Did you conduct any scientific experiment --

2 MS. BROWN: Objection to form.

3 BY MR. HILDABRAND:

4 Q. -- in providing this article?

5 MS. BROWN: Same objection.

6 THE WITNESS: Have I conducted
7 scientific experiments before writing this article?
8 Yes.

9 BY MR. HILDABRAND:

10 Q. Did you conduct a scientific experiment to
11 contribute to writing this article?

12 A. Scientific experimentation was not a part of
13 writing this article.

14 Q. Thank you for clarifying. So there wasn't --
15 this article doesn't involve a control and
16 experiment group?

17 MS. BROWN: Objection to form.

18 THE WITNESS: There is no control or
19 experiment group in this paper.

20 BY MR. HILDABRAND:

21 Q. All right. Was there any statistical --
22 original statistical analysis conducted in this
23 article?

24 MS. BROWN: Objection to form.

25 THE WITNESS: This paper does not

1 include original statistical analysis.

2 BY MR. HILDABRAND:

3 Q. Does this article reflect your opinion at the
4 time, along with the opinions of the other authors
5 listed?

6 MS. BROWN: Objection to form.

7 THE WITNESS: This article reflects our
8 experiences and practices and recommendations at the
9 time.

10 BY MR. HILDABRAND:

11 Q. So on PDF page one, the first page here,
12 Journal page 242, in the middle column, can you read
13 the first two sentences here, starting with
14 therefore?

15 A. I'm not seeing. At the top of the second
16 column?

17 Q. Do you see a therefore, the purpose of this
18 paper is?

19 A. Yes.

20 Q. Do you mind reading that sentence and then
21 the sentence that follows it?

22 A. Sure. Therefore, the purpose of this paper
23 is to outline several possible opportunities for
24 mental providers or other healthcare professionals
25 to advocate for transgender and gender diverse

1 patients, TGD patients, in order to address their
2 psychosocial needs, enhance health outcomes, and
3 promote resiliency across setting. Do you want me
4 to continue?

5 Q. If you want to finish the second sentence.
6 Sorry about that.

7 A. Do you want me to read the second sentence,
8 too?

9 Q. Yes.

10 A. Okay. We hope to highlight various
11 strategies or actions providers can take as needed
12 to support patients and their families on an
13 individual, community, or systemic scale.

14 Q. Was a purpose of this paper to encourage
15 advocacy by mental health professionals?

16 MS. BROWN: Object to form.

17 THE WITNESS: Define what you mean by
18 advocacy.

19 BY MR. HILDABRAND:

20 Q. How do you understand the word "advocacy" as
21 used in this paper?

22 A. I would need to review this paper more
23 specifically.

24 Q. Okay. We'll do that. Let's look at the
25 left-hand column here.

1 A. Okay.

2 Q. Do you see about halfway down, where you
3 describe studies about how transgender individuals
4 are more likely to consider suicide?

5 A. I believe I know where you're looking.

6 Q. Is it consistent with your experience and
7 practice that transgender individuals are more
8 likely to consider suicide?

9 MS. BROWN: Objection to form.

10 THE WITNESS: The question of
11 comparison, more likely than what?

12 BY MR. HILDABRAND:

13 Q. More likely than, for example, cisgender
14 individuals?

15 MS. BROWN: Objection to form.

16 THE WITNESS: Can you restate the
17 question for me, please?

18 BY MR. HILDABRAND:

19 Q. Of course. Is it your experience and
20 practice that transgender individuals are more
21 likely to consider suicide than cisgender
22 individuals are?

23 MS. BROWN: Same objection.

24 THE WITNESS: There is a body of
25 evidence which suggests that transgender individuals

1 may have higher percentages of suicidality or
2 suicide attempts when compared to their cisgender
3 peers.

4 BY MR. HILDABRAND:

5 Q. I know it's a weighty subject, but have any
6 of your patients ever attempted suicide?

7 A. Unfortunately, I have had patients who have
8 attempted suicide in the past, yes.

9 Q. Have any attempted suicide after beginning a
10 patient-provider relationship with you?

11 MS. BROWN: Object to form.

12 THE WITNESS: Individuals have attempted
13 suicide after establishing a therapeutic
14 relationship with me as their provider.

15 BY MR. HILDABRAND:

16 Q. About how many patients in that category have
17 attempted suicide?

18 A. I can think of two individuals who have
19 attempted suicide.

20 Q. Toward the bottom of the left column, do you
21 see where you say that healthcare professionals and
22 mental health counselors in particular are in a
23 unique position to recognize, respond to, and
24 advocate for the multifarious and complex needs of
25 TGD youth? Do you see that?

1 A. I do.

2 Q. Just to clarify, what are TGD youth?

3 A. TGD stands for transgender or gender diverse.

4 Q. Are there other individuals in the gender
5 diverse category who are not transgender?

6 MS. BROWN: Object to form.

7 THE WITNESS: There are individuals who
8 identify as gender diverse.

9 BY MR. HILDABRAND:

10 Q. Who would not identify as transgender?

11 A. There are individuals who identify as various
12 gender identities which are broadly conceptualized
13 as gender diverse that do not specifically identify
14 as transgender.

15 Q. Thank you.

16 A. Uh-huh.

17 Q. Then here I think you mention that: However,
18 professionals may hesitate to step into the role of
19 patient advocate for a variety of reasons, including
20 a lack of awareness about appropriate resources for
21 SGN patients and fear of overstepping their
22 boundaries as a provider or operating outside the
23 bounds of their competence, even if they feel
24 strongly about the cost. Is that what the authors
25 wrote here?

1 A. Yes. That's in the text.

2 Q. Is this a valid concern for health
3 professionals to be hesitant about engaging in
4 advocacy?

5 MS. BROWN: Object to form.

6 THE WITNESS: I'm not sure what is meant
7 by valid concerns.

8 BY MR. HILDABRAND:

9 Q. Is it acceptable for health professionals to
10 hesitate or not step into the role of patient
11 advocate?

12 MS. BROWN: Same objection.

13 THE WITNESS: Acceptable would be a
14 matter of personal preference and attitude.

15 BY MR. HILDABRAND:

16 Q. So some health professionals may have
17 personal preferences not to step into the role of
18 patient advocate; is that correct?

19 MS. BROWN: Same objection.

20 THE WITNESS: Some professionals may
21 hesitate for various reasons to step into a role of
22 advocate for their patient.

23 BY MR. HILDABRAND:

24 Q. Is it unprofessional for a health
25 professional to decide not to step into the role of

1 a patient advocate?

2 MS. BROWN: Objection to form.

3 THE WITNESS: I think we would need to
4 define what patient advocate means or what the term
5 "advocate" means.

6 BY MR. HILDABRAND:

7 Q. How did you understand the term "patient
8 advocate" as it's used here?

9 A. Uh-huh. So my impression of the term
10 "patient advocate", as represented in this article,
11 would be professional who is acting or seeking in
12 the best interest of their patient and seeking to
13 ensure that their patient is getting the care that
14 they need.

15 Q. Does that include speaking to individuals
16 other than the patient?

17 MS. BROWN: Objection to form.

18 THE WITNESS: In what way?

19 BY MR. HILDABRAND:

20 Q. Would that include speaking to elected
21 officials?

22 MS. BROWN: Objection the form.

23 THE WITNESS: It would be a question of
24 what role that professional was playing in various
25 behaviors.

1 BY MR. HILDABRAND:

2 Q. Is it normal for psychologists to discuss
3 transgender medicine with elected officials?

4 MS. BROWN: Objection to form.

5 THE WITNESS: Define what you mean by
6 normal.

7 BY MR. HILDABRAND:

8 Q. In your professional expertise and
9 experience, is it often the case that psychologists
10 are expected as part of being a psychologist to
11 discuss transgender medicine issues with elected
12 officials?

13 MS. BROWN: Same objection.

14 THE WITNESS: So the American
15 Psychological Association, for example, has
16 information about professional roles and
17 responsibilities and would be perhaps one governing
18 body that might be able to answer the question
19 related to the role of a psychologist in this
20 manner.

21 BY MR. HILDABRAND:

22 Q. Is it an appropriate role of psychologists to
23 tell politicians what laws to pass or not to pass?

24 MS. BROWN: Objection to form.

25 THE WITNESS: It would be an appropriate

1 role for a psychologist or mental health
2 professional to have conversations and to provide
3 information that may inform practices that I would
4 say, that impact truly their patient population.

5 BY MR. HILDABRAND:

6 Q. Do you consider that provision of information
7 to elected officials advocacy?

8 MS. BROWN: Objection to form.

9 THE WITNESS: It would, again, be a
10 question of the definition of advocacy.

11 BY MR. HILDABRAND:

12 Q. Would that be part of your definition of
13 advocacy is the question, the provision of
14 information to elected officials on transgender
15 medicine?

16 MS. BROWN: Objection to form.

17 THE WITNESS: I think there are many
18 possible definitions and as we said advocacy may
19 take shape.

20 BY MR. HILDABRAND:

21 Q. Would you understand that under your
22 definition of advocacy to include discussing laws
23 relating to transgender medicine with elected
24 officials? Is that according to your definition of
25 advocacy, advocacy?

1 MS. BROWN: Same objection.

2 THE WITNESS: Informing legislation that
3 benefit or harm an individual and the patient
4 population may be a role of a psychologist in terms
5 of protecting the wellbeing of their patient
6 population and advocating or truly supporting rather
7 than advocating the needs and wellbeing of their
8 patients.

9 BY MR. HILDABRAND:

10 Q. Let's turn to the upper right-hand column in
11 the first full paragraph here.

12 Do you see where it says: For example,
13 imagine you are working with a student who
14 identifies as nonbinary and is repeatedly
15 misgendered with consistent incorrect pronoun usage
16 by one of their teachers. As the provider, you
17 offer to reach out to their teacher to express your
18 concerns and request they change their classroom
19 behavior to become more affirming but the patient
20 declines and indicates they would like to talk with
21 their teacher independently first.

22 Is a psychologist talking with a patient's
23 teacher advocacy?

24 MS. BROWN: Objection to form.

25 / /

1 BY MR. HILDABRAND:

2 Q. Sorry. To clarify, is a psychologist talking
3 with a patient's teacher about the usage of pronouns
4 advocacy?

5 MS. BROWN: Same objection.

6 THE WITNESS: I think the psychologist
7 talking with a patient's teacher about any of their
8 mental health needs, including about the possibility
9 and importance of using that individual's pronouns,
10 is within the role of a psychologist to speak to the
11 wellbeing and needs of their client.

12 BY MR. HILDABRAND:

13 Q. Including if the psychologist feels it
14 necessary, the teacher's use of what the
15 psychologist used as incorrect pronouns, correct?

16 A. The use of incorrect pronouns has been widely
17 established in the literature as a harmful,
18 destructing experience for transgender individuals.
19 And so as a psychologist and mental health provider,
20 it might be important to collaborate with a patient
21 around their needs in the school setting and then to
22 discuss what would be supportive of their mental
23 health and reducing or eliminating their distress at
24 school.

25 BY MR. HILDABRAND:

1 Q. What are the correct pronouns to use for a
2 nonbinary student?

3 MS. BROWN: Objection to form.

4 THE WITNESS: Pronouns vary by
5 individuals. It would be important to collaborate
6 and discuss with each individual what were their
7 pronouns.

8 BY MR. HILDABRAND:

9 Q. Could they include pronouns other than he/him
10 or she/her?

11 A. They could.

12 Q. Could they include pronoun such as they/them
13 to refer to an individual student?

14 A. It might, yes.

15 Q. Could they include pronouns other than the
16 ones we just discussed to refer to that student?

17 A. Yes, it could.

18 Q. What should a psychologist do if the teacher
19 says that she does not want to use what she used as
20 biologically inaccurate pronouns?

21 MS. BROWN: Object to form. Sorry.

22 BY MR. HILDABRAND:

23 Q. Should the teacher -- should the psychologist
24 still recommend that the teacher use the pronouns
25 the teacher views as biologically inaccurate?

1 MS. BROWN: Same objection.

2 THE WITNESS: I don't understand what's
3 meant by biologically accurate or inaccurate
4 pronouns.

5 BY MR. HILDABRAND:

6 Q. Sure. I'll explain. So imagine that there
7 were a child whose sex assigned at birth is female
8 but the child identifies as nonbinary and prefers
9 the pronouns they/them. If the teacher says that
10 she will only use she/her pronouns to refer to the
11 student, is that incorrect of a teacher to do so?

12 MS. BROWN: Object to form.

13 THE WITNESS: For an individual who has
14 expressed that they do they/them pronouns, those
15 would ideally be the pronouns that are used for that
16 individual across settings. Use of other pronouns,
17 and particularly use of pronouns consistent with
18 their sex assigned at birth, have been demonstrated
19 to be damaging to that individual's mental health
20 and may worsen experiences of gender dysphoria.

21 BY MR. HILDABRAND:

22 Q. Could it damage the mental health of the
23 teacher if she were forced to use the they/them
24 pronouns in that scenario?

25 MS. BROWN: Object to form. And scope.

1 THE WITNESS: I would be curious what
2 you mean by damage the teacher's mental health.

3 BY MR. HILDABRAND:

4 Q. So you said it can be hurtful to the student
5 for the teacher to fail to use the pronouns the
6 student prefers. But what about the teacher? Could
7 it be harmful to a teacher to be forced to use
8 pronouns that do not match the child's sex assigned
9 at birth?

10 MS. BROWN: Same objection. Scope.

11 THE WITNESS: So my practice tends to
12 focus on children and adolescents and young adults.
13 I have not evaluated teachers in this particular
14 instance who may have this experience.

15 BY MR. HILDABRAND:

16 Q. So you would not be able to offer an expert
17 opinion about the mental health of the teachers?

18 MS. BROWN: Objection to form.

19 THE WITNESS: It is not within the scope
20 of the expert report I offered.

21 BY MR. HILDABRAND:

22 Q. Thank you. Also on here it describes
23 role-playing sessions with nonbinary or transgender
24 students to prepare for having those discussions
25 with teachers.

1 Have you engaged in role-playing sessions
2 with nonbinary or transgender patients before they
3 discuss the issue of the use of pronouns with
4 teachers or family?

5 MS. BROWN: Objection to form.

6 THE WITNESS: Can you repeat the
7 specific question for me?

8 BY MR. HILDABRAND:

9 Q. Have you engaged in role-playing sessions of
10 the sort described here in the right column that you
11 recommend for psychologists to do? Have you engaged
12 in such role-playing discussions with students about
13 playing through the student, the transgender and
14 nonbinary student, discussing with the teacher or a
15 parent the pronouns that the student prefers?

16 A. The use of role play is a common activity in
17 child and adolescent mental health and I -- from
18 what I can recall, I have engaged in role play with
19 transgender or nonbinary individuals.

20 BY MR. HILDABRAND:

21 Q. Is that something that insurance companies
22 would reimburse your time for?

23 MS. BROWN: Objection to form, and
24 objection to scope.

25 THE WITNESS: So I do not know the ins

1 and outs of billing. But, yes, my understanding is
2 that that is a common and respected practice in
3 psychotherapy to engage in interpersonal role play,
4 and I have no evidence to suggest that it is not
5 reimbursable.

6 BY MR. HILDABRAND:

7 Q. I won't go into billing practices, but are
8 any of your patients on Medicaid?

9 MS. BROWN: Objection to scope. This is
10 like nothing that -- like at all relevant.

11 MR. HILDABRAND: Again, if you have an
12 objection, you can note objection to form, objection
13 to scope, but not speaking objections.

14 BY MR. HILDABRAND:

15 Q. Can you please answer my question?

16 MS. BROWN: I'm going to be very clear
17 that it's my right and I will speak and so I would
18 appreciate if you didn't say that again. I'm not
19 going to go back and forth with you but it's the
20 right under the case law and the rules. So, again,
21 the objection stands. You can continue to ask your
22 question.

23 MR. HILDABRAND: Yes. And also in the
24 case law not to give speaking objections.

25 / /

1 BY MR. HILDABRAND:

2 Q. Can you please answer the question. Are any
3 of your patients on Medicaid?

4 MS. BROWN: Same objection. Scope.
5 Relevance.

6 THE WITNESS: Many of my psychotherapy
7 clients have commercial insurance. Patients in the
8 VPATH Clinic have TennCare, which I believe would be
9 consistent with medicaid.

10 BY MR. HILDABRAND:

11 Q. All right. Thank you. Now, let's go to PDF
12 page two. This is page 243 in the article, left
13 column. Can you see the paragraph that starts, for
14 example?

15 A. I believe so, yes.

16 Q. And so it says here: For example, consider
17 the case of a transgender adolescent male who is
18 forbidden by his high school to participate in
19 extracurricular activities in his affirmed gender.

20 Was that a case that one of the authors of
21 this article encountered?

22 A. We have many cases of individuals who may be
23 forbidden from participating in activities in their
24 affirmed gender. And as far as this scenario was
25 based on a particular case, yes.

1 Q. Was it based on one of your patient's case or
2 if you can remember?

3 A. I would need to review the example to be
4 certain.

5 Q. So it goes on to say: Therefore, upon
6 obtaining consent from a patient, his healthcare
7 provider advocated directly on his behalf by
8 expressing concern to school administrators in a
9 letter of support.

10 If you can remember, who was the healthcare
11 provider who advocated directly?

12 A. Review of the additional context in this
13 paragraph, the information above that sentence, I
14 believe this particular paragraph is about a patient
15 of mine, although many of the providers in our
16 Interdisciplinary Clinic also write letters of
17 support.

18 Q. So is that patient at a school in Tennessee?

19 A. I'm trying to recall which patient this may
20 have been specifically. Many of my patients are in
21 Tennessee. Clinic also supports patients in other
22 surrounding states as well.

23 Q. And if you can't remember, that's fine, and
24 we can move on. But do you recall at this point in
25 time?

1 A. I -- I think I am remembering the patient.

2 And, yes, it was a student in Tennessee.

3 Q. All right. Continuing in the middle column
4 here.

5 A. Uh-huh.

6 Q. Do you see where: As is to be expected,
7 sociopolitical factors often dictate the extent to
8 which the school system may be able to accommodate
9 requests and adapt their policies? It goes on, and
10 feel free to read the rest of the sentence if you
11 want to.

12 But what did you mean here by sociopolitical
13 factors?

14 A. My interpretation of sociopolitical factors
15 in this context in this paragraph and in the article
16 could be referring to a number of things, but would
17 include correct legislation.

18 Q. What sort of legislation? Is that what you
19 said?

20 A. Uh-huh.

21 Q. Do you mean like the legislation in this case
22 or is there other legislation that you have in mind?

23 MS. BROWN: Objection to form.

24 THE WITNESS: It may be legislation such
25 as in this case or legislation pertaining to other

1 transgender-related concerns.

2 BY MR. HILDABRAND:

3 Q. So the sentence goes on to say: However, it
4 has been our experience that educational staff
5 members will hear and respond to individual requests
6 to the extent possible.

7 Has that been your experience here in
8 Tennessee?

9 A. I have experienced many educators to be
10 responsive and kind but not all.

11 Q. Going down this column, it describes -- and
12 feel free to read it if you want to. Going down the
13 column and on to the right-hand side here, that
14 column, it describes compromises that are sometimes
15 reached with other members of the extracurricular
16 activities. For example, I believe here the school
17 district may agree that an individual youth can be
18 offered the opportunity to participate in
19 extracurricular activities in their affirmed gender
20 if the parents of other team members agree and offer
21 a statement of support.

22 Is that a compromise that you have been aware
23 has been reached here in Tennessee at any point in
24 time?

25 MS. BROWN: Object to the form.

1 THE WITNESS: What would be the specific
2 compromise in question, again?

3 BY MR. HILDABRAND:

4 Q. Asking other parents if they'd consent to
5 having the transgender individual play on the sports
6 team that he or she prefers?

7 MS. BROWN: Object to form.

8 THE WITNESS: I'm sorry, I think I got
9 lost. So a question about asking other parents --
10 can you repeat it one more time for me? I'm so
11 sorry.

12 BY MR. HILDABRAND:

13 Q. No. It's been a long day. So this describes
14 a compromise where other parents on the team are
15 asked whether or not they would consent to an
16 individual who wants to play on the team that
17 matches their gender identity would consent to that
18 individual playing on the team. Is that a
19 compromise that you are aware any team in Tennessee
20 has reached in the past few years?

21 A. So if I am reading correctly, I'm not seeing
22 specifically related to this instance of a team,
23 although it may be reflective of an athletic policy
24 and submitting that language in the report, but
25 that -- let's see. I'm reading again.

1 Q. I guess it refers to extracurricular
2 activity. Is that the language that it uses?

3 A. Yes. Extracurricular activities in their
4 affirmed gender. And then I could see if other team
5 members. Uh-huh.

6 Q. Is there a compromise that you're aware has
7 been reached at any point in Tennessee?

8 A. I am not aware of that particular compromise
9 being reached in Tennessee. I think the case in
10 question, if I'm recalling correctly, was about an
11 individual who wished to go on an overnight band
12 trip.

13 Q. Thank you. All right. Let's turn to page
14 three in the PDF, page 244 in the Journal. I'll go
15 to the top left column.

16 A. Page three of the PDF, top left. Okay.

17 Q. And then let's go to the first full
18 paragraph. Do you see where it says: Consider the
19 case of?

20 A. Yes.

21 Q. So it says: Consider the case of the TGD
22 adolescent who experienced bullying when using the
23 restroom associated with their affirmed gender at
24 school. Is that what the first line here says?

25 A. Yes.

1 Q. And feel free to read through silently if you
2 want to the rest of the paragraph. But does it say
3 at the end that -- just one second. Sorry. The
4 next paragraph begins: The school system was
5 initially frustrated and resisting to making such
6 accommodations as they believe they had already
7 provided reasonable accommodation. However, they
8 were ultimately swayed by persistent advocacy and
9 articulation of the patient's need in a sensitive
10 matter. Do you see that?

11 A. I see that statement, yes.

12 Q. Does this describe a case where you advocated
13 on behalf of the patient or one of the other authors
14 advocated on behalf of the patient?

15 A. I'm not certain. I'm not recalling this
16 particular case in my own practice.

17 Q. Then about midway down through that
18 paragraph, do you see where it says: Although the
19 provider was singularly focused in advocating for
20 the youth's right and need to feel comfortable and
21 safe using the restroom of their choosing. He goes
22 on to describe the presentation of this information
23 was balanced and validated the school's concerns.

24 Is it appropriate for a professional to be
25 singularly focused only on the individual patient's

1 rights when doing this sort of advocacy?

2 MS. BROWN: Objection to form.

3 THE WITNESS: I'm not sure what you
4 mean. Can you restate the question, please?

5 BY MR. HILDABRAND:

6 Q. So when a provider is doing advocacy about
7 bathroom use for transgender or nonbinary youth, is
8 it acceptable, professionally acceptable for the
9 provider to be singularly focused only on the
10 patient's interest?

11 MS. BROWN: Objection to form, scope,
12 and relevance.

13 THE WITNESS: I think it can be very
14 important for a healthcare professional to be
15 focused in what are the needs of their patient that
16 would support their health and wellbeing.

17 BY MR. HILDABRAND:

18 Q. Is that the only interest a psychologist
19 should consider?

20 MS. BROWN: Object to the form.

21 THE WITNESS: What other interests would
22 we be considering?

23 BY MR. HILDABRAND:

24 Q. That's my question. What other interests
25 should the psychologist consider?

1 MS. BROWN: Same objection.

2 THE WITNESS: So the question is what
3 are other interests a psychologist should consider?

4 BY MR. HILDABRAND:

5 Q. Before engaging in this advocacy, are there
6 any other interests the psychologist should
7 consider?

8 MS. BROWN: Same objection.

9 THE WITNESS: I think it would be
10 appropriate for a psychologist, mental health
11 provider or other healthcare professional, to be
12 focused on their patient's needs and what supports
13 their health and wellbeing.

14 BY MR. HILDABRAND:

15 Q. Anything else that they should be focused on?

16 MS. BROWN: Same objection.

17 THE WITNESS: I think it would depend
18 and there are probably lots of other things that
19 providers could focus on. But that is an organizing
20 principle in much of the work that we do is to
21 promote health and wellbeing in our patients.

22 BY MR. HILDABRAND:

23 Q. All right. Turn to the right column. Do you
24 see the paragraph that begins, data are lacking?

25 A. Toward the bottom of the page? Yes, I am

1 seeing that.

2 Q. So does it read: Data are lacking but
3 anecdotally parental responses to their SGM youth
4 are often affected by factors such as culture,
5 socioeconomic status, and religious beliefs? Has
6 that been your experience and practice?

7 A. My experience has been that parental
8 responses vary and can be influenced by a variety of
9 factors, including but not limited to those that are
10 listed.

11 Q. How should a psychologist respond when the
12 child expresses a gender identity inconsistent with
13 the child's sex assigned at birth but the parents
14 disagree and say that the child is not transgender?
15 What should a psychologist do?

16 MS. BROWN: Objection to form.

17 THE WITNESS: The question is about an
18 individual child or adolescent who has a gender
19 identity incongruent with their sex assigned at
20 birth and the parents are not supportive? Is that
21 right?

22 BY MR. HILDABRAND:

23 Q. And the parents do not agree that the child
24 is transgender, should the child still be treated as
25 transgender?

1 MS. BROWN: Same objection.

2 THE WITNESS: So in the psychologist's
3 practice, we would really look to the best practice
4 guidelines, including the WPATH and the Endocrine
5 Society to help us navigate complex individualized
6 patient situations. We would collaborate with the
7 youth and their caregiver to determine an
8 appropriate course of action that really promotes
9 the health and wellbeing of that individual patient.

10 BY MR. HILDABRAND:

11 Q. Have you ever treated a patient as
12 transgender where the parents disagree about whether
13 the child is transgender?

14 MS. BROWN: Objection to form.

15 THE WITNESS: I have worked with
16 individuals who identified as transgender and
17 parents were not supportive of their child's gender
18 identity.

19 BY MR. HILDABRAND:

20 Q. When you say not supportive, do you mean that
21 the parents do not agree that the child was
22 transgender?

23 MS. BROWN: Object to the form.

24 THE WITNESS: I am not sure about
25 parents' agreement with whether the child is

1 transgender or not. But I do recall consents where
2 their caregivers were not supportive of their
3 identity and exhibited behaviors accordingly,
4 including not using their child's name and pronoun,
5 which has been largely demonstrated in the
6 literature as important to the health and wellbeing
7 of the transgender individual.

8 BY MR. HILDABRAND:

9 Q. So was it psychologically -- in your opinion,
10 in those cases where the parents refused to use the
11 child's preferred pronoun, did that cause
12 psychological harm to the patient?

13 MS. BROWN: Object to form.

14 THE WITNESS: I think the term
15 "psychological harm" would be complicated and we
16 would want to break that down further. It is very
17 potentially damaging and distracting to an
18 individual child when their parents and others do
19 not use their name and pronouns.

20 BY MR. HILDABRAND:

21 Q. So in your experience as a psychologist, it
22 can be damaging to the child if the parent declines
23 to use the child's preferred pronouns?

24 A. Yes.

25 Q. Should parents make the final decision about

1 how to treat children in adolescence who have
2 expressed a transgender gender identity?

3 MS. BROWN: Object to form.

4 BY MR. HILDABRAND:

5 Q. Let me rephrase. Should parents make the
6 final decision about how to treat children in
7 adolescence who have expressed that their gender
8 identity is inconsistent with their sex assigned at
9 birth?

10 MS. BROWN: Same objection.

11 THE WITNESS: I think the decisions
12 about how to treat the child who has expressed their
13 gender identity is different from or incongruent
14 with their sex assigned at birth, decisions about
15 how to move forward are -- that information is
16 really informed by the guidelines, such as in the
17 WPATH, in which we are striving to work together and
18 that a mental health provider, for example, would be
19 collaborating with that patient and their caregiver
20 to develop a treatment plan and to work towards what
21 would promote health and resiliency for that
22 individual.

23 BY MR. HILDABRAND:

24 Q. I understand it would be complex. You might
25 want to discuss -- provide your opinion and discuss

1 that with the patient and the parents. But at the
2 end of the day, who makes the final decision about
3 how to treat a minor child? Is it the patient
4 child? Is it the psychologist or other health
5 provider? Or is it the parents?

6 MS. BROWN: Again, objection to form.

7 THE WITNESS: I think in the field of
8 child development and for the cisgender and gender
9 diverse individuals, for all people and all
10 children, right, but ideally the treatment of the
11 child is made collaboratively with that child's
12 wishes and voice as a part of the discussion.

13 BY MR. HILDABRAND:

14 Q. So is it your opinion that even in situations
15 where laws do not dictate a treatment one way or the
16 other, parents are not the final decision maker for
17 health decisions for minor transgender children and
18 adolescents?

19 MS. BROWN: Objection to form.

20 THE WITNESS: Is the question about who
21 makes medical decisions?

22 BY MR. HILDABRAND:

23 Q. Who is the final decision maker? Is it the
24 parents?

25 A. I'm not sure what final decision maker means.

1 In our practice and my clinical experience, those
2 decisions around patient care are made
3 collaboratively between the patient, their legal
4 guardian, and their treatment team.

5 Q. Okay. So to give an example, if you
6 recommend that a patient start hormone therapy, the
7 patient/minor child would like to start hormone
8 therapy but the parents say no. Do the parents get
9 to make that decision and not start hormone therapy
10 for their minor child?

11 MS. BROWN: Object to form.

12 THE WITNESS: In our practice, legal
13 guardian consent is required to begin a course of
14 treatment.

15 BY MR. HILDABRAND:

16 Q. So VPATH would not start a course of
17 treatment like that without receiving parental or
18 other legal guardian permission, correct?

19 A. What treatment specifically?

20 Q. Hormone therapy is the example we were using
21 in our discussion, I think.

22 A. Thanks for the reminder. I appreciate it.
23 VPATH would not initiate hormone therapy without
24 legal guardian consent.

25 Q. On PDF page four, Journal page 260 -- or 245,

1 let's turn there. It mentions the Trans Buddy
2 Program down here in the right column, the bottom
3 right of the column, around the middle of the page.

4 A. Yes, I see it.

5 Q. Can you describe what the Trans Buddy Program
6 is?

7 A. Sure. So I am not affiliated with that
8 program. I'll do my best to describe what I
9 understand it to be. The Trans Buddy Program is a
10 part of the program for LGBTQ Health at Vanderbilt
11 University Medical Center. And the trans study
12 program includes a trained volunteer who can serve
13 as a patient and guardian's request for a variety of
14 reasons, from initiating appointments at the medical
15 center, all the way through conclusion of the visits
16 and receiving support thereafter.

17 Q. Do any of your patients have a trans buddy
18 assigned to them?

19 A. I don't know that trans buddies are assigned,
20 per se, to follow an individual over time. Patients
21 in my clinic in VPATH have relied on support from a
22 trans buddy in the past.

23 Q. Other than cases such as child abuse by a
24 parent, are parents given access to all of their
25 minor children's medical information at Vanderbilt

1 University Medical Center that you're aware of?

2 MS. BROWN: Object to form.

3 THE WITNESS: So I'm not sure of all the
4 ins and outs of when parents are given access to the
5 records for children and adolescents. They are, I
6 believe, provided the option and information about
7 the pathways to receive all of that information.

8 BY MR. HILDABRAND:

9 Q. Have you heard the phrase -- do you know what
10 My Health at Vanderbilt is, or MHAV?

11 A. I do.

12 Q. What a My Health at Vanderbilt account would
13 be?

14 A. Yes. Sorry to interrupt.

15 Q. Sorry to interrupt you as well. Can you just
16 explain what your understanding of that would be?

17 A. Uh-huh. My Health at Vanderbilt is a patient
18 portal consistent with my chart, which is a common
19 practice for medical systems across the country.
20 And it allows access to communicate with your
21 provider, to schedule appointments, to pay your
22 bill, to navigate all of your experiences in the
23 Medical Center.

24 MR. HILDABRAND: Travis, can you
25 circulate what I believe is Document J, VUMC Website

1 Parental Access.

2 THE WITNESS: I think it might be in the
3 chat. And if we could take a break in a few
4 minutes, that might be great.

5 MR. HILDABRAND: If you want to take a
6 break, now is fine with me if you want to take a
7 break. Would you like --

8 MS. BROWN: Sure. Let's say ten
9 minutes.

10 THE WITNESS: Thank you.

11 (Recess observed.)

12 MR. HILDABRAND: Let's go back on the
13 record. I have four hours and five minutes is what
14 we have spent on the record so far.

15 BY MR. HILDABRAND:

16 Q. So let's go back to the document circulated
17 as Doc J, which we will enter as Exhibit 9.

18 (WHEREUPON, a document was marked as
19 Exhibit Number 9.)

20 BY MR. HILDABRAND:

21 Q. Dr. Cyperski, does this appear to be a screen
22 capture from a Vanderbilt University Medical Center
23 website?

24 A. It looks consistent with the website, yes.

25 Q. So going down to the bottom of PDF page one,

1 sorry -- going down to -- going down to page -- PDF
2 page two, do you see where it says, Children age 13
3 to 17?

4 A. Yes, I see that.

5 Q. So does it say there: If your child is
6 between the ages of 13 to 17 and you need to obtain
7 My Health at Vanderbilt access follow these steps.
8 If you are the biological parent, you can complete
9 the application at the child's next appointment or
10 download and complete the form below. My Health at
11 Vanderbilt Account Access for Children 13 to 17.
12 Bring it with you to the child's next appointment or
13 visit the nearest Vanderbilt walk-in clinic as your
14 government issued photo ID has to be verified.
15 Ensure your child signs the application as well.
16 Did I read that accurately?

17 A. Yes.

18 Q. And then does it say: Access to My Health at
19 Vanderbilt can be granted within the clinic once the
20 application is turned into the clinic staff? Did I
21 read that accurately?

22 A. That's what it says.

23 Q. Has one of your patients or their parents
24 ever provided to you with this form?

25 A. I have not received this form. This type of

1 administrative work is often handled at the front
2 desk.

3 Q. Does it appear from this website that without
4 this form parents would not have access to a child
5 age 13 to 17 to their data on My Health at
6 Vanderbilt?

7 MS. BROWN: Objection to form.
8 Objection to scope. Objection to relevance.

9 THE WITNESS: It appears as though this
10 website is describing how parents can gain access to
11 My Health at Vanderbilt for children 13 to 17.

12 MR. HILDABRAND: Travis, can you
13 circulate Doc I. So this would be Exhibit 10.

14 (WHEREUPON, a document was marked as
15 Exhibit Number 10.)

16 BY MR. HILDABRAND:

17 Q. Dr. Cyperski, can you read to me, at the top
18 of this, does it say: Vanderbilt University Medical
19 Center Parental Access to the My Health at
20 Vanderbilt, MHAV, account of a teen 13 to 17 years
21 old? Is that what it says at the top of the first
22 page?

23 A. It does say that.

24 Q. And turn to page two of this document. Do
25 you see about a little less than midway down, where

1 it says: I understand that I may revoke this access
2 at any time by asking my doctor to do so? Is that
3 what it says here?

4 A. I see that in the text, yes.

5 Q. And a few lines above, does it say: Teen's
6 agreement?

7 A. Yes.

8 Q. Have you ever seen this form before or a
9 completed version of this form before?

10 A. I have not.

11 Q. For any of the patients that you treat, are
12 legal guardian parents not granted access to their
13 My Health at Vanderbilt accounts?

14 MS. BROWN: Objection to form.

15 Objection to relevance. Objection to scope.

16 THE WITNESS: For the patients in my
17 practice, I am not aware of patients who do not have
18 parents or legal guardian access to My Health at
19 Vanderbilt unless they are adults.

20 MR. HILDABRAND: Let's return to --
21 before I return, though, for opposing counsel,
22 objection to form, relevance, and scope, do you
23 understand relevance and scope to be outside of
24 objection to form?

25 MS. BROWN: I am preserving the

1 objections that I want to preserve. And yes, I do
2 understand this to be outside of the objection to
3 form.

4 MR. HILDABRAND: So unless you say
5 relevance and scope, you have not objected to
6 relevance and scope? Is that your understanding?

7 MS. BROWN: Again, I'm going to make the
8 objections I'm going to make and that's all that I
9 can -- I can say any further, Clark.

10 MR. HILDABRAND: I understand. But if
11 you're -- please keep your objections short. If you
12 don't think that form covers relevance and scope, of
13 course do so. It's common practice for form to
14 cover both of those. So by using additional
15 language beyond that, my concern is that you are
16 coaching the witness. And so if you really think
17 that those are outside of objection to form then of
18 course you can use those. But if you think those
19 are covered by objection to form, then please leave
20 your objection to objection to form.

21 MS. BROWN: Again, I'm going to make the
22 objections I'm going to make. As an attorney I
23 would never coach my client and, again, I understand
24 them to be especially in this context of this case
25 and this witness, to be exactly the objections that

1 I have made. But I have noted your concerns and
2 they are on the record. Thank you.

3 MR. HILDABRAND: Thank you. I'll
4 understand that there are additional there.

5 BY MR. HILDABRAND:

6 Q. All right. Let's go back to the Journal, PDF
7 page five, Journal page 246. And just to clarify, I
8 think this was Document H. Do you see in the bottom
9 left column where it says: Providers who are
10 interested in offering high quality care to TGD
11 youth are encouraged to be aware that they will be
12 called to go above and beyond for their patients by
13 promoting wellness and supporting collaboration,
14 coordination, or continuity of care outside the
15 standard appointment time. Is that what it says
16 there?

17 A. It does, yes.

18 Q. So is it common for psychologists to treat
19 their patients outside the standard appointment
20 time?

21 A. It was standard practice. There are a
22 variety of activities that require completion
23 outside of the standard appointment time.

24 Q. And top of the middle column, do you see the
25 sentence that says: Therefore, providers can play

1 an important role in advocating at the state and
2 federal level for legislation that honors, protects,
3 and serves the SGM community? Is that what you
4 wrote?

5 A. I see that statement, yes.

6 Q. Do you offer any expert testimony about what
7 legislation that honors, protects, and serves the
8 SGM community is?

9 MS. BROWN: Objection to form.

10 THE WITNESS: Testimony in what context?

11 BY MR. HILDABRAND:

12 Q. In this case, in your report?

13 MS. BROWN: Same objection.

14 THE WITNESS: Can you repeat the
15 question for me?

16 BY MR. HILDABRAND:

17 Q. Yes. So you used the phrase in this article,
18 advocating at the state and federal level for
19 legislation that honors, protects, and serves the
20 SGM community. Do you provide --

21 A. Uh-huh.

22 Q. Do you provide any expert testimony about
23 what such legislation is or is not?

24 MS. BROWN: Objection to form.

25 THE WITNESS: I provide an opinion and

1 information in the report around the legislation in
2 question in this case and practices that honor,
3 protect, and serve the SGM community, which would
4 include transgender individuals.

5 BY MR. HILDABRAND:

6 Q. So in the next paragraph, middle column, I
7 believe you -- do you specifically cite legislation
8 proposed by the Tennessee State Legislature in 2020?
9 Do you see that?

10 A. I do.

11 Q. And you say that these healthcare
12 professionals collaborated with community agencies,
13 legal experts, and lobbyists to draft expert
14 testimony to be presented to legislators; is that
15 correct?

16 A. I see that healthcare professionals
17 collaborated with community agencies, legal experts,
18 and lobbyists, yes.

19 Q. Did you draft expert testimony to present to
20 legislators regarding this 2020 legislation?

21 MS. BROWN: Object to form.

22 THE WITNESS: I drafted expert
23 testimony.

24 BY MR. HILDABRAND:

25 Q. What expert testimony -- what legislation was

1 that expert testimony about?

2 A. I did not end up providing expert testimony
3 in 2020 but my colleagues in the Interdisciplinary
4 Clinic have.

5 Q. So you yourself did not draft expert
6 testimony about 2020 legislation; is that correct?

7 A. I drafted testimony.

8 Q. Yes. So what legislation did you draft
9 testimony about?

10 A. I drafted testimony about the legislation
11 that would prevent prescribing hormones to
12 prepubertal children. I am forgetting the specific
13 number to the legislation.

14 BY MR. HILDABRAND:

15 Q. Was your draft for or against the
16 legislation?

17 A. It was against the legislation.

18 Q. Did you send this draft to anyone?

19 A. I do not recall specifically, although it is
20 possible we were collaborating with lobbyists and
21 experts at Vanderbilt Medical Center. And so it is
22 possible that I shared a draft with them.

23 Q. Which lobbyists were you collaborating with?

24 A. Forgive me, I'm trying to recall. So we
25 partnered with professionals at Vanderbilt

1 University Medical Center, as well as lobbyists with
2 Emap, whose name I believe was Jim Schmidt
3 (phonetic) and his company.

4 Q. And have they requested that you draft this
5 or is that something you just decided to do
6 yourself?

7 A. I don't recall the specifics.

8 Q. Did that legislation that you had drafted, a
9 document in opposition to, did it pass the Tennessee
10 Legislature?

11 A. It did.

12 Q. Have you pinned any op ed pieces opposing
13 pieces of Tennessee legislation?

14 MS. BROWN: Object to form.

15 THE WITNESS: I have not.

16 BY MR. HILDABRAND:

17 Q. Have you posted commentaries on social media
18 about Tennessee legislation?

19 MS. BROWN: Object to form. And
20 objection to scope.

21 THE WITNESS: Not that I recall.

22 BY MR. HILDABRAND:

23 Q. Have you signed any petitions about Tennessee
24 legislation?

25 MS. BROWN: Same objections.

1 THE WITNESS: I do not recall about
2 Tennessee specific legislation.

3 BY MR. HILDABRAND:

4 Q. Did you advocate for or against the
5 legislation challenged in this case before its
6 passage?

7 MS. BROWN: Object to the form.

8 THE WITNESS: I do not recall.

9 BY MR. HILDABRAND:

10 Q. Are there any other legislation in Tennessee
11 or outside of Tennessee that you have advocated for
12 or against because you are a psychologist?

13 MS. BROWN: Objection to form.
14 Objection to scope. And objection to relevance.

15 THE WITNESS: I along with members of
16 the medical community may have signed petitions that
17 were not in support of legislation that targeted the
18 transgender community.

19 BY MR. HILDABRAND:

20 Q. Targeted the transgender community in what
21 ways, if you can remember?

22 A. I suspect that there may have been petitions
23 against healthcare bills that would be banning
24 affirmative care for transgender individuals --
25 / /

1 BY MR. HILDABRAND:

2 Q. What sorts of care --

3 A. -- or other --

4 Q. Sorry.

5 A. No. Or other concerns may also have been
6 represented. I'm not sure.

7 Q. What sorts of affirmative care are you
8 talking, just because that can mean a broad
9 category? Do you mean hormone therapy?

10 A. Affirmative care -- uh-huh. I'm sorry?

11 Q. Would hormone therapy be included in the
12 category of affirmative care you mentioned?

13 A. Hormone therapy is one of many components of
14 affirmative care.

15 Q. Are you concerned that it might weaken
16 societal respect for psychologists or other mental
17 health providers if they engaged in such advocacy?

18 MS. BROWN: Objection to form.

19 THE WITNESS: The question is about
20 weakening public respect?

21 BY MR. HILDABRAND:

22 Q. Yes.

23 A. Okay. No, I'm not concerned that -- that
24 psychologists speaking on behalf of their patient
25 means would generate disrespect for mental health

1 professionals.

2 Q. Do you have any other concerns about
3 psychologists engaging in that sort of advocacy?

4 MS. BROWN: Objection to form.

5 THE WITNESS: There are other concerns
6 about engaging in speaking on behalf of patients,
7 including fear potentially of being targeted or
8 harassed by the public.

9 BY MR. HILDABRAND:

10 Q. So the concerns are more about the public
11 targeting or harassing psychologists; is that
12 correct?

13 MR. HILDABRAND: Objection to form.

14 THE WITNESS: Yes. I believe there is
15 fear in the community of mental health providers and
16 other healthcare providers about the repercussions
17 from the community.

18 BY MR. HILDABRAND:

19 Q. On the right column of this PDF page five,
20 Journal page 246, do you see where it describes
21 establishing affirmative schools? Healthcare
22 professionals can work with educational personnel to
23 establish affirmative schools. Do you see that?

24 A. Which page is that on? I'm sorry.

25 Q. PDF page five, 246 in the Journal pagination.

1 The right column, kind of upper right.

2 A. I don't think I'm seeing the sentence or
3 statement that you are looking for. Can you say it
4 again, please?

5 Q. Of course. Do you see: In the community in
6 settings where youth interact frequently, healthcare
7 professionals can work with educational personnel to
8 establish affirmative schools and spaces that
9 provide a safe place for TGD patients?

10 A. Yes. I have located that.

11 Q. Can you explain for me what an affirmative
12 school is as you used that phrase here?

13 A. So we likely used the term "affirmative
14 school" to represent schools that engage in
15 affirmative practices that have been well
16 established in support of transgender students.

17 Q. Are you an expert in educational practices?

18 MS. BROWN: Objection to form.

19 THE WITNESS: I am not an educator or an
20 expert in educational practices.

21 BY MR. HILDABRAND:

22 Q. All right. So that's -- those are all the
23 questions about that article. But before we leave
24 this document, can you turn to PDF page six, Journal
25 page 247.

1 What is the title of the article that
2 followed the one that you co-authored?

3 A. It says: Advocacy Opportunities from
4 Academics Community Partnership. Three Examples
5 from Transcollaboration.

6 Q. Are articles about advocacy the sorts of
7 articles that often appear in this sort of journal?

8 MR. HILDABRAND: Objection to form.

9 THE WITNESS: I believe this journal
10 called The Behavior Therapist is a part of
11 professional organizations of psychologists and
12 mental health professionals and this particular
13 journal had a call for submission related to
14 supporting special patient population.

15 BY MR. HILDABRAND:

16 Q. So they specifically requested articles about
17 supporting patient populations such as transgender
18 children and adolescents?

19 A. I believe that's true. Yes.

20 Q. Okay. Let's go back to your expert report.
21 This is Exhibit 1, Doc A. And we're going to go to
22 footnote eight, which is on page five of the report.

23 A. Okay. We're there.

24 Q. Do you see where you cited an article by
25 Rafferty, J.?

1 A. Yes.

2 Q. Insuring Comprehensive Care and Support for
3 Transgender and Gender-Diverse Children and
4 Adolescents; is that the title of the article it
5 appears?

6 A. Yes.

7 MR. HILDABRAND: All right. Travis, can
8 you circulate Document R. We'll mark this as
9 Exhibit 11, I believe is the number we're on.

10 (WHEREUPON, a document was marked as
11 Exhibit Number 11.)

12 BY MR. HILDABRAND:

13 Q. Dr. Cyperski, is this the article by Jason
14 Rafferty that you cited in your expert report?

15 A. It appears so, yes.

16 Q. Now, was this article, I believe it has a
17 date down at the bottom of the page of October 2018;
18 is that correct?

19 A. Yes.

20 Q. So this is published less than four years ago
21 from today; is that correct?

22 A. If the math is right, yes.

23 Q. Is this an article from the American Academy
24 of Pediatrics? Is that what it says in the bottom
25 right?

1 A. It does.

2 Q. Are you a pediatrician?

3 A. I am not.

4 Q. Is this the sort of article that you would
5 rely upon, though, as a psychologist?

6 A. I'm not sure that I would rely on this
7 article and it was cited in context of the report
8 and we could consider it in that context.

9 Q. Fair enough. Let's turn to -- it's Table 1
10 but it's on page two of the PDF.

11 A. Table 1, yes, we're there.

12 Q. Do you see it says: Relevant terms and
13 definitions related to gender care?

14 A. Uh-huh.

15 Q. What is the first term?

16 A. The first term is sex.

17 Q. Can you read the definition of sex in
18 Table 1?

19 A. Sure. It says: An assignment that is made
20 at birth, usually male or female, typically on the
21 basis of external genital anatomy but sometimes on
22 the basis of internal gonads, chromosomes, or
23 hormone levels.

24 Q. Do you agree with this definition of sex or
25 is there an alternative definition that you provide?

1 Just let me know if you would tweak it in any way or
2 provide a different definition.

3 MS. BROWN: Objection to form.

4 THE WITNESS: This appears to be an
5 acceptable definition.

6 BY MR. HILDABRAND:

7 Q. Does this table define the term "gender" by
8 itself?

9 A. I am not seeing that.

10 Q. Can you look at the term at the definition of
11 agender about halfway down through the table and can
12 you read that definition for us?

13 A. Uh-huh. Agender: A term used to describe a
14 person who does not identify as having a particular
15 gender.

16 Q. All right. In your professional experience,
17 would you agree that some people do not have a
18 particular gender?

19 MS. BROWN: Object to form.

20 THE WITNESS: In my experience an
21 individual may identify as agender.

22 BY MR. HILDABRAND:

23 Q. In your experience, would someone identify as
24 not having a particular gender?

25 A. I have not heard someone use the terms of "I

1 don't have a particular gender". I have heard
2 people use the gender identity label of agender.

3 Q. Do any of your patients use that label to
4 describe themselves?

5 A. I do not believe so.

6 Q. Let's go down to page three, under where it
7 says, Mental Health Implications.

8 A. Okay. We are there.

9 Q. Do you see where it says: Evidence suggests
10 that an identity of TGD has an increased prevalence
11 among individuals with autism spectrum disorder but
12 this association is not yet well understood? Would
13 you agree with that sentence, or are there any parts
14 of that sentence that you disagree with?

15 MS. BROWN: Object to form.

16 THE WITNESS: If this is one statement
17 within some broader context, I don't see a reason to
18 object with this statement.

19 BY MR. HILDABRAND:

20 Q. All right. Do you see farther down in this
21 column where it says: Some youth who identify as
22 TGD also experience gender dysphoria. Are there
23 some youth who identify as transgender or gender
24 diverse who do not experience gender dysphoria?

25 A. Some individuals of transgender identity or a

1 gender diverse identity do not experience gender
2 dysphoria.

3 Q. Would it be acceptable in the standards of
4 care to provide puberty blockers to a transgender
5 individual who does not experience gender dysphoria?

6 MS. BROWN: Objection to form.

7 THE WITNESS: My interpretation of the
8 practice guidelines suggests that yes, it may be
9 appropriate.

10 BY MR. HILDABRAND:

11 Q. Would it also be appropriate to provide
12 hormone therapy to a transgender individual who does
13 not have gender dysphoria?

14 MS. BROWN: Objection to form.

15 THE WITNESS: So the decision about
16 whether to pursue hormone therapy would be made
17 between the patient and their legal guardians and
18 their treatment team and the guidelines would
19 support and inform the treatment plan.

20 BY MR. HILDABRAND:

21 Q. So a treatment plan might include hormone
22 therapy for a transgender individual who does not
23 have gender dysphoria if in those individual
24 circumstances the patient health provider and legal
25 guardian or parent decide on that course of action?

1 MS. BROWN: Object to form.

2 THE WITNESS: So the treatment plan for
3 gender incongruence and what would be specifically
4 required by the individual in question, that would
5 be decided upon -- the treatment plan, to be clear,
6 would be decided upon in collaboration and through
7 an evaluation of the patient in collaboration with
8 their legal guardian, and with their treating
9 provider.

10 BY MR. HILDABRAND:

11 Q. And so yes or no? It might include hormone
12 therapy even if the individual does not have gender
13 dysphoria?

14 MS. BROWN: Same objection.

15 THE WITNESS: Yes. The treatment plan
16 may include hormones for an individual with gender
17 incongruence.

18 BY MR. HILDABRAND:

19 Q. So you're using a different term here. For
20 an individual who does not have gender dysphoria,
21 yes or no, could you answer that question not using
22 the term "gender incongruence"?

23 MS. BROWN: Same objection.

24 THE WITNESS: Can you repeat the
25 question for me then?

1 BY MR. HILDABRAND:

2 Q. Yes. For a transgender individual who does
3 not have gender dysphoria -- we can have the
4 conversation about gender incongruence in a minute.
5 But for a transgender individual who does not have
6 gender dysphoria, might it be acceptable for that
7 individual or might their treatment plan include
8 hormones? Yes or no? And then provide any
9 additional explanation you'd like.

10 MS. BROWN: Same objection.

11 THE WITNESS: Yes. A treatment plan for
12 a transgender individual with or without gender
13 dysphoria may include the use of gender-affirming
14 hormones as, again, would be decided upon after
15 careful and thoughtful evaluation, collaboration
16 among all the parties we've discussed before -- the
17 patient, particularly in adolescence, their legal
18 guardian, and their treatment team.

19 BY MR. HILDABRAND:

20 Q. And might a treatment plan for a transgender
21 individual who does not have gender dysphoria also
22 include surgery? Yes or no? And then any further
23 explanation.

24 MS. BROWN: Same objection.

25 THE WITNESS: We would look to the

1 guidelines to support decisions about treatment
2 planning. But it is possible that an individual who
3 identifies as transgender or gender diverse may not
4 experience gender dysphoria and could decide or move
5 forward with gender-affirming surgery.

6 BY MR. HILDABRAND:

7 Q. All right. So you mentioned the term "gender
8 incongruence". What does that mean?

9 A. Uh-huh. So gender incongruence would be
10 similar to what we've discussed before around gender
11 identity, in which an individual's gender identity
12 would be incongruent or does not match or is not
13 aligned with the sex they were assigned at birth.

14 BY MR. HILDABRAND:

15 Q. Is that a mental health condition to be
16 gender incongruent?

17 MS. BROWN: Objection to form.

18 THE WITNESS: It is not a mental health
19 condition and is not considered to be pathological
20 to have a transgender identity or experience gender
21 incongruence.

22 MR. HILDABRAND: Thank you. All right.
23 Travis, turn to page five in this document. It's
24 page five in the PDF and that's also the page that
25 is here. Make our life real easy. Go to where you

1 can see pubertal suppression.

2 MS. BROWN: Sorry. Give us one moment.
3 The mouse went out.

4 MR. HILDABRAND: Of course, yes.

5 BY MR. HILDABRAND:

6 Q. Can you read the first sentence under
7 pubertal suppression?

8 A. Just so I remember, this is the AAP
9 publication; is that right?

10 Q. Yes. It's --

11 A. Okay.

12 Q. -- the American Academy of Pediatrics.

13 A. Okay. Thank you. Under pubertal
14 suppression, it says: Gonadotrophin-releasing
15 hormones have been used to delayed puberty since the
16 1980s for central precocious puberty.

17 Q. Thanks.

18 A. Do you want me to keep going?

19 Q. No, that's fine. Is that your understanding
20 as well that these have been used since around the
21 1980s?

22 A. That would be a great question for an
23 endocrinologist. However, that's my understanding.

24 Q. Would these gonadotrophin-releasing hormones,
25 are these often referred to as puberty blockers or

1 puberty suppressors?

2 A. Yes.

3 Q. Are some of your patients on puberty blockers
4 or puberty suppressors? And feel free to tell me
5 which term you prefer to refer to them.

6 A. Sure. In my mental health practice, I do not
7 believe I have patients that are currently on
8 puberty-blocking medications. So there are patients
9 in the VPATH Clinic who are on pubertal blockers.

10 MR. SANDERS: Clark, can I interrupt for
11 a second?

12 MR. HILDABRAND: Yes.

13 MR. SANDERS: This is David Sanders,
14 Madam Court Reporter. I'm going to log off at this
15 point. Jessica Jernigan Johnson in my office has
16 logged on. She's already counsel of record in the
17 case so she's just in for me.

18 MR. HILDABRAND: Sounds good. Thanks,
19 David.

20 MR. SANDERS: See you-all tomorrow.

21 MR. HILDABRAND: See you tomorrow.

22 BY MR. HILDABRAND:

23 Q. On the right-hand column --

24 A. Uh-huh.

25 Q. -- do you see about halfway down the page

1 where it says pubertal suppression is not without
2 risk?

3 A. Yes.

4 Q. Do you agree with that statement or is that
5 something that we should ask somebody else?

6 MS. BROWN: Objection to form.

7 THE WITNESS: Discussing the risks and
8 benefits of pubertal suppression is within the
9 specialty of endocrinology. So it may be a good
10 question for them.

11 BY MR. HILDABRAND:

12 Q. That's fair. Thank you. So turning to page
13 six in the PDF. When you get there, do you see a
14 Table 2, the process of gender affirmation may
15 include greater than or equal to one of the
16 following components?

17 A. Yes, I do.

18 Q. Do you see that table?

19 A. Yes, I do.

20 Q. Thank you. And is the first component social
21 affirmation?

22 A. That's what I'm seeing, yes.

23 Q. As a psychologist, is that something that you
24 can understand that component and speak about as an
25 expert?

1 A. Yes.

2 Q. The second one, is that puberty blockers?

3 A. Yes.

4 Q. Is that something that you can speak to as an
5 expert?

6 MS. BROWN: Objection to form.

7 THE WITNESS: I would be curious about
8 what speak to refers to and what questions you may
9 ask specifically.

10 BY MR. HILDABRAND:

11 Q. Are you offering any expert testimony about
12 puberty blockers?

13 MS. BROWN: Objection to form.

14 BY MR. HILDABRAND:

15 Q. Or do you have sufficient experience and
16 knowledge to offer expert testimony about puberty
17 blockers?

18 MS. BROWN: Objection to form.

19 THE WITNESS: I think it would depend on
20 the particular questions and context related to
21 pubertal blockers. We work within an
22 Interdisciplinary Clinic so often I myself need to
23 consult with the endocrinologist about some of these
24 terms and practices.

25 / /

1 BY MR. HILDABRAND:

2 Q. So you yourself don't prescribe the puberty
3 blockers; is that correct?

4 A. That's correct.

5 Q. And so the next component listed cross-sex
6 hormone therapy. And, again, you yourself do not
7 prescribe cross-sex hormones; is that correct?

8 A. That's correct.

9 Q. Is the phrase "cross-sex hormone" or
10 "cross-sex hormone therapy", are those phrases that
11 you have heard in your practice, though?

12 A. I have heard those terms. We now prefer the
13 term "gender-affirming hormones."

14 Q. About when in your practice did that
15 preference change?

16 MS. BROWN: Object to form.

17 THE WITNESS: Uh-huh. I'm not sure of
18 the specific time line. Again, the terminology and
19 practices are updating all the time. But I would
20 say within the past couple of years.

21 BY MR. HILDABRAND:

22 Q. Thank you. That's helpful. And then
23 gender-affirming surgeries, you don't perform
24 yourself gender-affirming surgeries; is that
25 correct?

1 A. I do not.

2 Q. Are you aware of what gender-affirming
3 surgeries might entail for your patients, though?

4 A. Yes.

5 Q. What sort of surgeries would you consider
6 gender-affirming surgeries?

7 A. Uh-huh. The table provides a pretty good
8 definition. So top surgery, which might include
9 creating a male typical chest shape (inaudible) --

10 (Court Reporter interrupts for clarity.

11 THE WITNESS: I'm reading from the
12 table. But top surgery, which would be to create a
13 male-typical chest shape or enhanced breasts. Then
14 there would be bottom surgery, which would be
15 surgery on genitals or reproductive organs. And
16 there may be surgeries such as facial feminization
17 or other procedures, including various other
18 procedures.

19 BY MR. HILDABRAND:

20 Q. For top surgery, you described creating a
21 male-typical chest shape or enhanced breasts?

22 A. Uh-huh.

23 Q. For someone born with a sex assigned at birth
24 of female, would that involve mastectomies?

25 A. Often I think this would be discussed between

1 an individual patient and their surgeon. But yes,
2 often there is a -- my understanding is there is a
3 double mastectomy and then re-creation of
4 affirmative chest.

5 Q. And for bottom surgery, I think it's
6 described as surgery on genitals or reproductive
7 organs. For those natal boys or individuals born
8 with the sex assigned at birth of male, would that
9 involve removing their penis and using it to
10 construct the vagina?

11 MS. BROWN: Object to form.

12 THE WITNESS: So for an individual
13 assigned male at birth, there may be a variety of
14 surgeries that they determine to be medically
15 necessary for each individual. And just remind
16 everyone that moving through gender-affirming
17 surgery or receiving gender-affirming surgery and
18 the treatment plans here are individualized to each
19 patient. So not all patients seek surgery to begin
20 with.

21 BY MR. HILDABRAND:

22 Q. But is that a surgery that some patients may
23 receive?

24 A. Which surgery is that?

25 Q. The removing -- cutting off their penis and

1 using that to shape an artificial vagina, is that a
2 bottom surgery that some natal boys may receive?

3 MS. BROWN: Object to form.

4 THE WITNESS: So I'm not sure as to the
5 details of how the surgeries are performed. That
6 would be a great question for a plastic surgeon.
7 But some individuals who may seek bottom surgery may
8 experience changes to their genitalia and creation
9 of genitalia that would be more consistent with
10 their gender identity.

11 BY MR. HILDABRAND:

12 Q. Have any of your patients received top
13 surgery?

14 MS. BROWN: Objection to form.

15 THE WITNESS: I have had patients who
16 have received top surgery, yes.

17 BY MR. HILDABRAND:

18 Q. What is the youngest age of a patient of
19 yours who has received top surgery?

20 A. This is a bit of a complex question and
21 nuanced about the way they practice. So I'm
22 thinking about patients in my mental healthcare
23 practice and I think the youngest I have worked with
24 them in my mental healthcare practice would be 18, I
25 believe.

1 Q. Eighteen at the time of the surgery; is that
2 correct?

3 A. Yes. Many are older and college aged.

4 Q. And what is the youngest age you can recall
5 for one of your patients receiving bottom surgery?

6 MS. BROWN: Objection to form.

7 THE WITNESS: I am not aware of that
8 bottom surgery performed on individuals younger than
9 18.

10 BY MR. HILDABRAND:

11 Q. So the same age for top surgery?

12 MS. BROWN: Object to form.

13 THE WITNESS: Can you repeat the
14 question for me?

15 BY MR. HILDABRAND:

16 Q. That's okay. We can -- we can move on.

17 That's all right. All right.

18 On PDF page eight, can you go there?

19 A. Page eight. Give us a minute.

20 Q. And the quotation will extend from the bottom
21 of page eight to page nine, if that's helpful for
22 what you're pulling up.

23 A. Okay. I think we're there.

24 Q. Thanks. Do you see the sentence that says:
25 Youth who identify as TGD are becoming more visible

1 because gender-diverse expression is increasingly
2 admissible in the media, on social media, and in
3 schools and communities.

4 Do you agree with this statement? And let me
5 know if there are any parts that you would disagree
6 with.

7 A. I think I would need some more information
8 about what the authors mean by admissible, a word
9 I'm not understanding in the context, I don't think.

10 Q. So other than the increase in admissible,
11 would you agree that youth who identified as TGD are
12 becoming more visible in the media, on social media,
13 and in schools and communities?

14 A. Yes, there is increased visibility of the
15 transgender community, although it is still quite
16 limited.

17 Q. All right. We're going to put this article
18 to the side and go back to your expert report.

19 A. Okay.

20 Q. It's Exhibit 1. We are just going back to
21 footnote eight here on page five.

22 A. Okay. We are there.

23 Q. Do you see where you cite the 2015 article
24 from the American Psychological Association,
25 Guidelines for Psychological Practice of Transgender

1 and Gender-Nonconforming People?

2 MR. HILDABRAND: Can y'all hear us?
3 Let's go off the record for a second while they
4 reestablish audio if that's all right.

5 (Recess observed.)

6 MR. HILDABRAND: Before we go back to
7 questions, I have that we are at four hours and 57
8 minutes on the record. Is that what opposing
9 counsel has as well?

10 MS. BROWN: That sounds accurate. We'll
11 trust you.

12 MR. HILDABRAND: All right.

13 MS. BORELLI: Are you tracking,
14 Ms. Honeycutt?

15 (Off-the-record discussion.)

16 MR. HILDABRAND: I hope we don't have to
17 use down to the last minute but we'll see. All
18 right.

19 BY MR. HILDABRAND:

20 Q. So going back, you saw where you cited the
21 2015 American Psychological Association article,
22 correct?

23 A. In footnote eight. Yes, I'm with you.

24 MR. HILDABRAND: Great. Travis, can you
25 circulate Doc M. And we'll mark this as Exhibit 12.

1 (WHEREUPON, a document was marked as
2 Exhibit Number 12.)

3 BY MR. HILDABRAND:

4 Q. Does this appear to be the article that you
5 cited in your expert report?

6 A. It does.

7 Q. Let's go to the second page in the PDF,
8 Journal page 833.

9 A. Okay.

10 Q. Do you see at the first full paragraph where
11 it says: Given the added complexity of working with
12 TGNC and gender-questioning youth and the
13 limitations of available research, the guidelines
14 focus primarily, though not exclusively, on TGNC
15 adults? Is that what the article says?

16 A. I see that text, yes.

17 Q. Do you agree that there is added complexity
18 with working with transgender and gender-questioning
19 youth?

20 MS. BROWN: Object to form.

21 THE WITNESS: The mental health field in
22 general, I believe that there is added complexity
23 working with children and adolescents of all gender
24 identity. That includes cisgender children and
25 adolescents.

1 BY MR. HILDABRAND:

2 Q. And are there any limitations to the
3 available research regarding transgender and
4 gender-questioning youth?

5 MS. BROWN: Objection to form.

6 THE WITNESS: There are limitations in
7 every field of research and particular to each
8 article they may have their own limitations.

9 BY MR. HILDABRAND:

10 Q. Are there any limitations particular to
11 research regarding transgender and
12 gender-questioning youth?

13 MS. BROWN: Same objection.

14 THE WITNESS: Particular in what way?

15 BY MR. HILDABRAND:

16 Q. So you mention that all fields can have
17 limitations. Are there any limitations that you can
18 think of specifically for research regarding
19 transgender and gender-questioning youth?

20 MS. BROWN: Same objection.

21 THE WITNESS: No.

22 BY MR. HILDABRAND:

23 Q. So these are just limitations that any field
24 of research would have?

25 MS. BROWN: Objection to form.

1 THE WITNESS: There may be limitations
2 present in all fields of study, and I cannot think
3 of unique limitations in this field of study.

4 BY MR. HILDABRAND:

5 Q. Do you use these guidelines in this article
6 during your practice as a psychologist?

7 MS. BROWN: Objection to form.

8 THE WITNESS: I have reviewed these
9 guidelines. We primarily rely on the Endocrine
10 Society and the WPATH.

11 BY MR. HILDABRAND:

12 Q. So these guidelines are -- you might consider
13 these guidelines, but these are not guidelines that
14 you would rely upon as much as the WPATH Standards
15 of Care or the Endocrine Guidelines; is that
16 correct?

17 MS. BROWN: Objection to form.

18 THE WITNESS: These are guidelines I
19 have reviewed and considered. And the standards of
20 care from the WPATH and the Endocrine Society
21 Guidelines are the primary sources in our field.

22 BY MR. HILDABRAND:

23 Q. Thank you. Do these guidelines in this
24 article focus primarily on adults?

25 MS. BROWN: Objection to form.

1 THE WITNESS: I would need to re-review
2 this particular article.

3 BY MR. HILDABRAND:

4 Q. So you're not aware off the top of your head
5 if this article focuses primarily on adults?

6 MS. BROWN: Same objection.

7 THE WITNESS: Off of the top of my head,
8 I recall this article references both youth and
9 adults.

10 BY MR. HILDABRAND:

11 Q. That's fair. On the right-hand side, do you
12 see where it says distinction between standards and
13 guidelines?

14 A. I do.

15 Q. Can you read the sentence under that heading?

16 A. Sure. So it says: When using these
17 guidelines, psychologists should be aware that APA
18 has made an important distinction between standards
19 and guidelines. Should I keep going?

20 Q. Yes. If you want to keep going for the next
21 sentence.

22 A. All right. The standards are mandates to
23 which all psychologists must adhere, e.g., the
24 ethical principles, a psychologist, and code of
25 conduct, whereas guidelines are aspirational.

1 Q. Do you agree that guidelines are
2 aspirational?

3 MS. BROWN: Objection to form.

4 THE WITNESS: I think guidelines are
5 guidelines that can inform in a very important way
6 treatment plans and best practice.

7 BY MR. HILDABRAND:

8 Q. Do you view there as being a distinction
9 between guidelines and standards of care?

10 MS. BROWN: Same objection.

11 THE WITNESS: In this context, as
12 referenced in this article, I understand the
13 distinction that they're making between standards
14 and guidelines.

15 BY MR. HILDABRAND:

16 Q. Is that a distinction you make in your
17 practice as a psychologist?

18 MS. BROWN: Objection to form.

19 THE WITNESS: I am not sure I have
20 really thought in depth about the definition between
21 standards and guidelines.

22 BY MR. HILDABRAND:

23 Q. All right. Now let's look at page three in
24 the PDF. Do you see it says foundational knowledge
25 and awareness?

1 A. Yes.

2 Q. And it says: Guideline one: Psychologists
3 understand that is gender is a nonbinary construct
4 that allows for a range of gender identities and
5 that a person's gender identity may not align with
6 sex assigned at birth?

7 A. Yes. Uh-huh.

8 Q. Do you agree with the statements in that
9 guideline or are there any that you disagree with?

10 A. I can agree with that statement.

11 Q. For the first sentence that says rationale,
12 can you read the first sentence there?

13 A. Yes. It says: Gender identity is defined as
14 a person's deeply felt, inherent sense of being a
15 girl, woman, or female, a boy, a man, or male, a
16 blend of male or female, or an alternative gender.

17 Q. Do you agree with that statement or are there
18 any components of it that you disagree with?

19 A. So this is one particular statement in what I
20 believe is an older document, if I remember
21 correctly, and is in process of being updated. I
22 think it could be stated better and more precisely
23 in a future iteration.

24 Q. And this was published, I think at the bottom
25 it says December 2015; is that what it says?

1 A. Yes.

2 Q. It's already outdated less than seven years
3 later; is that correct?

4 MS. BROWN: Object to form.

5 THE WITNESS: So seven years can be a
6 long time in scientific literature. There may be
7 many advances in that time. It's likely that when
8 these guidelines and papers such as these are
9 developed that they are in the works for many years
10 and in committee for many years prior to their
11 publication date.

12 BY MR. HILDABRAND:

13 Q. Do you agree that gender identity can be a
14 blend of male or female?

15 A. Yes, I think gender identity could be a
16 blend.

17 Q. All right. Let's go forward to page 11 in
18 the PDF. This is Journal page 842. Do you see the
19 paragraph that begins: A clear distinction between
20 care of TGNC and gender-questioning children and
21 adolescents exists in the literature?

22 A. Yes, I see that paragraph.

23 Q. Can you read the next sentence there?

24 A. Sure. I'm going to read the first sentence
25 again just so I'm in the right place. Sorry. A

1 clear distinction between care of TGNC and
2 gender-questioning children and adolescents exists
3 in the literature due to the evidence that not all
4 children persist in a TGNC identity into adolescence
5 or adulthood and because no approach to working with
6 TGNC children has been adequately empirically
7 validated consensus does not exist regarding best
8 practice with prepubertal children.

9 Q. Do you agree that reasonable psychologists
10 can differ about the proper treatment of transgender
11 youth?

12 MS. BROWN: Objection to form.

13 THE WITNESS: And what do you mean by a
14 reasonable psychologist?

15 BY MR. HILDABRAND:

16 Q. You tell me. Is that something that a
17 psychologist who you could respect could disagree
18 with how you approach treating a transgender child?

19 MS. BROWN: Same objection.

20 THE WITNESS: Professionals do sometimes
21 differ in their approach to treatment plans or
22 treatment strategies for children and all kinds of
23 conditions.

24 BY MR. HILDABRAND:

25 Q. Let's go to the next paragraph. Do you see

1 where it says: One approach encourages an
2 affirmation and acceptance of children's expressed
3 gender identity?

4 A. Yes, I see that paragraph.

5 Q. In your practice, is that more -- is that
6 similar to the approach that you try to take of
7 affirming the child's expressed gender identity?

8 MS. BROWN: Objection to form.

9 THE WITNESS: In my practice, I work
10 closely and intentionally with each patient and
11 their caregiver to assess their gender identity and
12 to collaborate on an appropriate treatment plan.

13 BY MR. HILDABRAND:

14 Q. And so then the next paragraph begins: In
15 the second approach, children are encouraged to
16 embrace their given bodies and to align with their
17 assigned gender roles. Is that what the article
18 says?

19 A. I think in that paragraph I'm going to repeat
20 it back just to be sure. In the second approach,
21 children are encouraged to embrace their given
22 bodies and to align with their assigned gender
23 roles. That's what this text states.

24 Q. Is that second approach consistent with your
25 practice?

1 MS. BROWN: Objection to form.

2 THE WITNESS: The approach that's
3 described in this statement I would need more
4 information around. At first blush, it sounds like
5 a practice that is no longer supported in the
6 literature.

7 BY MR. HILDABRAND:

8 Q. So then the next sentence says: This
9 includes endorsing and supporting behavior and
10 attitudes that align with the child's sex assigned
11 at birth prior to the onset of puberty. Is that an
12 approach that psychologists no longer take?

13 MS. BROWN: Objection to form.

14 THE WITNESS: So the statement -- this
15 includes endorsing and supporting behaviors and
16 attitudes that align with the child's sex assigned
17 at birth prior to onset of puberty. I think it
18 would be important to assess each individual child
19 and their needs. However, encouraging a transgender
20 child or gender incongruence to identify and behave
21 as their sex assigned at birth could be consistent
22 with something called conversion therapy.

23 Q. So do you view this second approach as
24 conversion therapy?

25 MS. BROWN: Objection to form.

1 THE WITNESS: I would need more
2 information about what the authors were intending
3 and maybe to read some additional context.

4 BY MR. HILDABRAND:

5 Q. Feel free to read the rest of the paragraph
6 if you want to but --

7 A. Sure.

8 Q. Do you want to do that? Then I'll return to
9 the question in a second?

10 A. Okay. That would be great. Thank you so
11 much. Okay. I finished reading that paragraph.

12 Q. Is conversion therapy -- before we get back
13 to this, is conversion therapy an acceptable or
14 unacceptable choice of therapy for a psychologist?

15 MS. BROWN: Objection to form.

16 THE WITNESS: Conversion therapy is
17 unacceptable and unethical. It's been found to be
18 harmful to patients.

19 BY MR. HILDABRAND:

20 Q. Based on what this second approach is
21 described as here, would you view this as conversion
22 therapy?

23 MS. BROWN: Objection to form.

24 THE WITNESS: Again, I would need some
25 more information. But it sounds consistent with

1 conversion therapy and I appreciate the context
2 later in the paragraph, that when addressing
3 psychological interventions for children and
4 adolescents, the WPATH standards of care identify
5 interventions "aimed at trying to change gender
6 identity and expression to become more congruent
7 with the sex assigned at birth as unethical, with
8 hopes that future research will offer improved
9 guidance in this area of practice".

10 BY MR. HILDABRAND:

11 Q. So based on what you see here, you would
12 agree with WPATH that this second approach would be
13 unethical?

14 MS. BROWN: Objection to form.

15 THE WITNESS: I would agree that
16 conversion therapy is unethical. And indeed the
17 American Psychological Association has also posted
18 statements in support of this belief as well since
19 the time that these guidelines came out.

20 BY MR. HILDABRAND:

21 Q. You mentioned at the time these guidelines
22 came out. Has this approach ever been viewed as
23 more acceptable amongst psychologists?

24 MS. BROWN: Objection to form.

25 THE WITNESS: Many years ago people were

1 practicing conversion therapy but it's very
2 important to note that this has been widely
3 identified and clearly articulated by mental and
4 medical health professionals and inappropriate,
5 unethical, and harmful --

6 BY MR. HILDABRAND:

7 Q. Just to be --

8 A. -- and no longer practiced.

9 Q. Just to be clear about many years, is that
10 ten years ago or longer?

11 A. I don't know the specifics of folks who
12 practice conversion therapy or have practiced
13 conversion therapy in the past.

14 Q. All right. So in the upper right column, do
15 you see where it says consensus does not exist
16 regarding whether this approach may provide benefits
17 or may cause harm or lead to psychosocial
18 adversities?

19 A. I see that statement listed here.

20 Q. Do you think that there is now consensus?

21 A. I do believe that there is consensus now
22 that conversion therapy is harmful.

23 Q. Farther down the right column on page 11, do
24 you see -- it's about halfway down in the first full
25 paragraph?

1 A. Uh-huh.

2 Q. Do you see where it says: Complicating their
3 clinical presentation, many gender-questioning
4 adolescents also present with co-occurring
5 psychological concerns, such as suicidal ideation,
6 self-injurious behaviors, drug and alcohol use, and
7 autism spectrum disorders? Is that what the article
8 says with additional in-line citations?

9 A. I see that in the article, yes.

10 Q. Do you agree with that statement? Are there
11 any components of it that you disagree with?

12 A. There are many possible co-occurring
13 conditions and it's very common in child adolescent
14 mental health broadly for there to be co-occurring
15 diagnoses or conditions.

16 Q. Do you see where it says: Additionally,
17 adolescents can become intensely focused on their
18 immediate desires?

19 A. I see that, yes.

20 Q. Is that something you observed about
21 adolescents in your practice?

22 MS. BROWN: Objection to form.

23 THE WITNESS: So questions about
24 adolescents who may become intensely focused on
25 immediate desires, I believe this is regarded as an

1 experience of adolescence, where they may be focused
2 on what brings them pleasure or are unable to delay
3 gratification for some individuals.

4 BY MR. HILDABRAND:

5 Q. Now I want to move forward to page 29 in the
6 PDF. It's page 860 in the Journal. Do you see
7 where it says Appendix A definitions?

8 A. Yes, I see Appendix A.

9 Q. Do you see the sentence: Terminology within
10 the healthcare field in transgender and gender
11 non-conforming TGNC communities is constantly
12 evolving?

13 A. Yes.

14 Q. Do you agree that this terminology is
15 constantly evolving?

16 A. I agree it is often evolving. Constantly is
17 a very specific frequency.

18 Q. Thanks for clarifying.

19 A. Sorry.

20 Q. The second sentence says: The evolution of
21 terminology has been especially rapid in the last
22 decade as the profession's awareness of gender
23 diversity has increased as more literature and
24 research in this area has been published and as
25 voices of the TGNC community have strengthened? Do

1 you agree with this statement?

2 A. I think there has been increased
3 proliferation of research and awareness of gender
4 diversity in the past decade, yes.

5 Q. Given the change that's occurred in the past
6 decade, as a psychologist, do you think that the
7 field of psychology should slow down a little bit or
8 take a more conservative approach to this change in
9 terminology?

10 MS. BROWN: Objection to form.

11 THE WITNESS: In best practices in the
12 mental health field, it has been well established
13 that using terminology consistent with our patients'
14 understanding of their culture and their identity is
15 important to delivering culturally competent care.
16 And in the fact that terminology may be changing and
17 evolving, it would be important to remain updated on
18 that terminology and to continue to meet our
19 patients where they're at, again, as consistent with
20 culturally competent care.

21 BY MR. HILDABRAND:

22 Q. So now I'm going to ask to scroll through the
23 definitions, specifically, since they go in
24 alphabetical order, pages 30 and 31, in the PDF
25 pages 861, 862 in the document. And let me know if

1 you see a definition of the word "gender" standing
2 by itself?

3 A. We are scrolling. I did not see a definition
4 on page 861. We've made it to the alphabetical
5 section of H and did not see a specific definition
6 for the term "gender".

7 Q. Thank you. On page 862, do you see a
8 definition of sex?

9 A. I see sex or sex assigned at birth.

10 Q. And is the first sentence there: Sex is
11 typically assigned at birth or before during
12 ultrasound based on the appearance of external
13 genitalia?

14 A. Yes, I see that.

15 Q. And feel free to read the additional context
16 they provide there in that definition. But once
17 you've done so, can you let me know if you agree
18 with the definition here or if they're related how
19 you would change it?

20 A. I've read the definition. I think the
21 current definition of sex and how sex is assigned,
22 including the many factors of informed sex, like
23 internal genitalia, chromosomal and hormonal sex,
24 that those would be considered for all individuals
25 and not just when external genitalia are ambiguous.

1 MR. HILDABRAND: Thank you for
2 clarifying. I believe we have entered this already
3 as Exhibit 12; is that correct?

4 COURT REPORTER: Yes, sir.

5 MR. HILDABRAND: Great. Thank you. I
6 just wanted to make sure before we moved on. All
7 right.

8 BY MR. HILDABRAND:

9 Q. Let's go back to Exhibit 1, your expert
10 report.

11 A. Okay.

12 Q. And we're still on for there page five, but
13 now we are going to turn to footnote nine.

14 A. I see footnote nine.

15 Q. Do you cite a state advocacy update there?

16 A. From the American Medical Association, yes.

17 MR. HILDABRAND: Travis, can you
18 circulate Doc N. And we will mark this as
19 Exhibit 13.

20 (WHEREUPON, a document was marked as
21 Exhibit Number 13.)

22 BY MR. HILDABRAND:

23 Q. Dr. Cyperski, does this appear to be the
24 March 26, 2021, state advocacy update from the AMA
25 that you've cited?

1 A. Yes.

2 Q. Are state advocacy updates the source or
3 sources that psychologists usually rely on in
4 forming their opinions?

5 MS. BROWN: Object to form.

6 THE WITNESS: This document deals within
7 the scope of the opinions that I provided.

8 BY MR. HILDABRAND:

9 Q. So would it be the sort -- so is it a
10 document you relied upon in forming your expert
11 opinion?

12 A. Yes.

13 Q. So you see where it says, AMA fights to
14 protect healthcare for transgender patients?

15 A. Yes.

16 Q. Is it normal for medical associations to
17 fight political battles?

18 MS. BROWN: Object to form.

19 THE WITNESS: Normally the specific
20 term, it is very common for professional
21 organizations to make policy statements or updates
22 such as this.

23 BY MR. HILDABRAND:

24 Q. Then in the last -- do you see the sentence,
25 before criminalizing healthcare for transgender

1 minors that says: The AMA state advocacy resource
2 center remains actively engaged in defeating
3 legislation that would harm transgender patients?

4 A. Yes, I see that statement.

5 Q. Are you aware that the AMA has an advocacy
6 resource center?

7 A. I am not familiar with the AMA organizational
8 structure but it is listed in this document that
9 they have an advocacy resource center.

10 Q. Is it customary for the AMA to actively
11 attempt to defeat legislation?

12 MS. BROWN: Objection to form.

13 THE WITNESS: Again, I'm not familiar
14 with the particulars of the AMA and their activities
15 within the organization. I think it makes sense
16 that physicians and professionals would work to
17 protect their patients and to defeat things
18 including legislation that would harm their
19 patients.

20 BY MR. HILDABRAND:

21 Q. Do you see farther down where it says: The
22 AMA used these bills as a dangerous legislative
23 intrusion into the practice of medicine and has been
24 working closely with state medical associations to
25 vigorously oppose them.

1 A. I see that statement, yes.

2 Q. Is it dangerous for state legislatures to
3 intrude into the practice of medicine?

4 MS. BROWN: Objection to form.

5 THE WITNESS: I think it would be
6 important to define the word "dangerous".

7 BY MR. HILDABRAND:

8 Q. So you cited this article to support your
9 expert report. How do you understand the word
10 "dangerous" as it is used here?

11 A. Uh-huh. So defining in context, might be AMA
12 used these bills as a harmful endeavor and dangerous
13 legislative intrusion into the practice of medicine
14 and working closely with state medical associations
15 to vigorously oppose them.

16 Q. So is some legislative intrusion into the
17 practice of medicine acceptable?

18 MS. BROWN: Object to form.

19 BY MR. HILDABRAND:

20 Q. Or not dangerous?

21 MS. BROWN: Same objection.

22 THE WITNESS: It's my experience that
23 the practice of medicine should be guided by best
24 practice guidelines and by the current state of the
25 literature and the science that guides their

1 practice.

2 BY MR. HILDABRAND:

3 Q. Not guided by the decisions of elected
4 officials?

5 MS. BROWN: Objection to form.

6 THE WITNESS: I am not aware of the fact
7 that elected officials are trained medical
8 professionals, although some of them may be. And to
9 the extent to which they are current and up to date
10 in the scientific literature about the practices of
11 medicine.

12 BY MR. HILDABRAND:

13 Q. So is it your position that only medical
14 professionals should decide how to limit the
15 practice of medicine?

16 MS. BROWN: Objection to form.

17 THE WITNESS: I believe the practice of
18 medicine should be informed by the current state of
19 the science, as well as by the patients that are
20 served by the medicine and populations of
21 individuals who are impacted by them and by many
22 other factors as well.

23 BY MR. HILDABRAND:

24 Q. So to give a yes or no, is it -- to yes or
25 no, should the practice of medicine only be

1 restricted by medical professionals? And then feel
2 free to explain.

3 MS. BROWN: Same objection.

4 THE WITNESS: It's very difficult to
5 answer any question when posed with an always or an
6 only or an absolute, and we often must consider the
7 complexities, particularly when it comes to the
8 health and wellbeing of people.

9 BY MR. HILDABRAND:

10 Q. All right. Now let's turn to page two of the
11 PDF. Do you see under where it says, excluding
12 transgender youth from athletics, where it says:
13 Another concerning trend are bills that would
14 prohibit transgender women and girls from
15 participating in school athletics consistent with
16 their gender identity?

17 A. I see the statement, yes.

18 Q. So do you understand the AMA to take the
19 position that these bills are a concerning trend?

20 A. Yes, that's my understanding.

21 Q. Are you concerned that the AMA is taking a
22 position on a political question?

23 MR. HILDABRAND: Objection to form.

24 THE WITNESS: Can you restate that, or
25 repeat the question for me, please?

1 BY MR. HILDABRAND:

2 Q. Yes. Is it a concern for you as a
3 psychologist that the AMA is picking sides in
4 political debates?

5 MS. BROWN: Same objection.

6 THE WITNESS: I'm not sure they are
7 picking sides in political debates and instead are
8 offering an opinion about what would promote health
9 and wellbeing and resiliency in a particular patient
10 population that they serve.

11 BY MR. HILDABRAND:

12 Q. All right. Move down to where it says: In
13 2020, Idaho became the first-ever state to enact a
14 ban on transgender minors' participation in youth
15 athletics. The law was challenged and blocked by a
16 federal court in August 2020. The AMA, along with
17 the American Academy of Pediatrics and other
18 healthcare organizations, submitted a Friend of the
19 Court brief with the Ninth Circuit Court of Appeals
20 noting that the law undermines the accepted approach
21 for treating gender dysphoria.

22 So is it your understanding that the AMA and
23 the American Academy of Pediatrics have taken a side
24 against the Idaho legislation?

25 A. Based on what's written in this document, it

1 appears as though the AMA and the AAP and other
2 healthcare organizations submitted a brief noting
3 that the law undermines the accepted approach for
4 treating gender dysphoria.

5 Q. So do you view the AMA as an impartial source
6 of information on the appropriateness of the law
7 challenged in this case?

8 MS. BROWN: Objection to form.

9 THE WITNESS: I believe the AMA is
10 taking a stance about what promotes wellbeing and
11 resiliency in patients that they treat, including
12 individuals with gender dysphoria, and seeking to
13 promote health and wellbeing for individuals with
14 gender dysphoria.

15 BY MR. HILDABRAND:

16 Q. So yes or no? Do you view them as impartial
17 on the Tennessee law challenged in this case? And
18 feel free to explain more.

19 MS. BROWN: Same objection.

20 THE WITNESS: I'm not sure how to answer
21 that question. I'm so sorry.

22 BY MR. HILDABRAND:

23 Q. If you're not sure that's fine. We'll move
24 on from that. Let's go back to your report, page
25 five, again, footnote nine.

1 A. Okay. Footnote nine.

2 Q. And then do you see the last citation on that
3 page to an AACAP 2019 article?

4 A. Yes.

5 MR. HILDABRAND: Travis, can you
6 circulate Doc O. Dr. Cyperski, we'll mark this as
7 Exhibit 14.

8 THE WITNESS: I have it open.

9 (WHEREUPON, a document was marked as
10 Exhibit Number 14.)

11 BY MR. HILDABRAND:

12 Q. Dr. Cyperski, does this appear to be the
13 AACAP statement that you cited in your expert
14 report?

15 A. Yes.

16 Q. Looking down at the third paragraph, do you
17 see the second sentence that reads: Blocking access
18 to timely care has been shown to increase youths'
19 risk for suicidal ideation and other negative mental
20 health outcomes?

21 A. I'm not seeing that yet.

22 MS. BROWN: There's a lag in my
23 scrolling. So if you can repeat it again.

24 BY MR. HILDABRAND:

25 Q. No problem.

1 A. What statement are we looking for?

2 Q. Sorry. The sentence is: AACAP strongly
3 opposes any efforts, legal, legislative, and
4 otherwise, to block access to these recognized
5 interventions.

6 A. I see that statement.

7 Q. So is the AACAP taking a side in debate about
8 legislation regarding transgender children and
9 adolescents?

10 MS. BROWN: Objection to form.

11 THE WITNESS: I am not sure AACAP is
12 taking a side so much as they are making a statement
13 that the types of legal and legislative acts are
14 incongruent with the current evidence-based clinical
15 care that is important to those promoting the health
16 and wellbeing of children and adolescents.

17 BY MR. HILDABRAND:

18 Q. So is the AACAP discouraging the passage of
19 this sort of legislation?

20 MS. BROWN: Same objection.

21 THE WITNESS: Their statement states:
22 AACAP opposed any efforts, legal, legislative, and
23 otherwise, to block access to these recognized
24 interventions.

25 / /

1 BY MR. HILDABRAND:

2 Q. So do you view AACAP as an impartial
3 organization when it comes to a law like the one
4 challenged in this case?

5 MS. BROWN: Objection to form.

6 THE WITNESS: I am not familiar enough
7 with AACAP and their organization in particular to
8 determine if they are impartial or not.

9 BY MR. HILDABRAND:

10 Q. Going back down to the first paragraph, do
11 you see the second sentence in that paragraph that
12 says: Health promotion for all youth encourages
13 open exploration of all identity issues, including
14 sexual orientation, gender identity, and/or gender
15 expression according to recognized practice
16 guidelines? Do you agree with this statement about
17 what health promotion involves?

18 A. Health promotion involves many various
19 components of lots of different practices, one of
20 which would be exploration of all aspects of
21 identity.

22 BY MR. HILDABRAND:

23 Q. Thank you. Let's put this to the side and go
24 back to your expert report. And we'll stay with
25 your expert report for a little bit longer this

1 time.

2 A. Okay.

3 Q. So look at paragraph 19, also on page five.

4 A. Paragraph 19, I see that.

5 Q. So you mention the widely accepted
6 guidelines. Are those the Endocrine Society
7 Guidelines and the WPATH Standards of Care?

8 A. Yes.

9 Q. Let's turn now to paragraph 20, which is on
10 page six. Can you read the first sentence there for
11 me?

12 A. Sure. The treatment for gender dysphoria is
13 to reduce or eliminate the individual's clinically
14 significant distress or impairments in functioning,
15 which includes helping the patient to live in
16 accordance with their gender identity.

17 Q. Is this the goal of treatment for gender
18 dysphoria?

19 A. Yes, though there may be others well.

20 Q. Is a goal for treatment of gender dysphoria
21 to help the child or adolescent become comfortable
22 in the body he or she was born with?

23 MS. BROWN: Object to the form.

24 THE WITNESS: A goal of treatment for
25 individuals with gender dysphoria would be to reduce

1 the distress or impairments that they feel and to
2 help them live in accordance with their gender
3 identity. That would be to decrease discomfort.

4 BY MR. HILDABRAND:

5 Q. But not to make them comfortable with their
6 sex assigned at birth; is that correct? Is it to
7 make them comfortable with their gender identity
8 rather than their sex assigned at birth; is that
9 correct?

10 MS. BROWN: Same objection.

11 THE WITNESS: I think this is a
12 complicated and nuanced issue that's hard to answer
13 distinctly and specifically and that the individual
14 treatment plan for a particular patient would
15 identify treatment goals for that individual.

16 BY MR. HILDABRAND:

17 Q. When you are creating patient treatment
18 plans, is it more important when you're creating
19 those for the individual to be comfortable with
20 their gender identity or to be comfortable with
21 their sex assigned at birth?

22 MS. BROWN: Objection to form.

23 THE WITNESS: Treatment plans often are
24 aimed at reducing distress and impairment and
25 improving positive psychology and functioning that

1 is often going to focus on supporting their gender
2 identity and helping them seek congruence in their
3 gender identity.

4 BY MR. HILDABRAND:

5 Q. For some patients, would it be more
6 helpful -- I understand that is how several patients
7 might be helped. But for some patients is it more
8 helpful to encourage them to be comfortable in their
9 sex assigned at birth rather than their gender
10 identity?

11 MS. BROWN: Objection to form.

12 THE WITNESS: I would need more
13 information about what you mean and what that
14 treatment would look like. Again, in the
15 description it sounds like the unethical practice of
16 conversion therapy.

17 BY MR. HILDABRAND:

18 Q. So going down -- so in the second sentence
19 here, you used the phrase "gender-affirming care".
20 Is that a commonly used phrased among psychologists?

21 A. Among psychologists in the field, yes.

22 Q. And the same for gender transition?

23 A. We in the field tend to use gender-affirming
24 care. Other terms like gender transition or
25 transition-related care may also fall in this realm.

1 Q. Would other care providers understand what
2 you mean when you use those terms?

3 MS. BROWN: Objection to form.

4 BY MR. HILDABRAND:

5 Q. Or do you understand what other healthcare
6 providers mean when they use those terms?

7 MS. BROWN: Objection to form.

8 THE WITNESS: I believe there is
9 consensus around gender-affirming care and would
10 understand what an individual was referring to,
11 though there's always room for further discussion
12 and collaboration with the provider about the
13 specific treatment that they're referencing.

14 BY MR. HILDABRAND:

15 Q. Moving down to paragraph 22. You say that --
16 we are talking about prepubertal children here. And
17 the second sentence says: For these patients,
18 social transition, living in accordance with one's
19 gender identity may be appropriate. Is that what
20 you said here?

21 A. Yes.

22 Q. And do you agree with that statement today?

23 A. That's correct.

24 Q. Might it also not be appropriate for some
25 prepubertal children who have gender dysphoria for

1 them to socially transition?

2 MS. BROWN: Objection to form.

3 THE WITNESS: So can you repeat the
4 question for me?

5 BY MR. HILDABRAND:

6 Q. Yes. So here it says: Social transition for
7 prepubertal children may be appropriate. Is it
8 always appropriate or are there scenarios where
9 social transitions to prepubertal children with
10 gender dysphoria is not appropriate?

11 MS. BROWN: Same objection.

12 THE WITNESS: I think there's two
13 distinctions here that are important. There's the
14 definition and practice of a social transition and
15 then there is gender dysphoria. And those two are
16 related and may inform one another but speak to the
17 complexities of developing a treatment plan and when
18 it may be appropriate to engage in which practice.

19 Q. So you say may be appropriate. So it may not
20 be appropriate in some treatment plans for
21 prepubertal children with gender dysphoria to
22 socially transition; is that correct?

23 A. For prepubertal children with gender
24 dysphoria specifically as a clinical diagnosis, it's
25 likely that a social transition is appropriate for

1 the majority of those patients.

2 BY MR. HILDABRAND:

3 Q. So for the majority of those patients, are
4 there some patients, even if they're minority, whom
5 social transition would not be an appropriate
6 treatment for gender dysphoria?

7 A. There are individual considerations for every
8 child and family. And in the majority of cases, if
9 a child has gender dysphoria, a social transition is
10 an important part of their treatment plan that would
11 promote health and wellbeing and resiliency.

12 Q. So percentage-wise when you say the majority,
13 you mean greater than 50 percent but less than 100
14 percent; is that correct?

15 A. In which patient population are we talking
16 about?

17 Q. So for prepubertal children with gender
18 dysphoria, you say it may be appropriate in some
19 situations. And then we discussed a little further
20 and you said a majority of prepubertal children with
21 gender dysphoria this would be appropriate. And I'm
22 sorry to talk quickly there.

23 But when you use the word majority, do you
24 mean greater than 50 percent but less than
25 100 percent?

1 A. In my personal practice, the individuals that
2 I have met that have a diagnosis of gender
3 dysphoria, it is often appropriate for them to
4 initiate a social transition and they have initiated
5 a social transition prior to arriving at my
6 practice.

7 Q. But give me the yes or no format and then
8 feel free to explain. Is it always appropriate for
9 a prepubertal child with gender dysphoria to
10 socially transition? Please give a yes or no and
11 then you can continue if you need to.

12 A. I really can't give a yes or no because using
13 terms like always, which are very complicated,
14 always, no. There are individual nuances and
15 circumstances that must be considered with every
16 patient. For the majority of individuals, a social
17 transition is appropriate.

18 Q. Thank you. So then I think it goes on to say
19 that: After an individual begins puberty, medical
20 intervention may be indicated, including puberty
21 delaying medications and/or hormone therapy to
22 initiate puberty consistent with one's gender
23 identity. Individuals who receive hormone therapy
24 develop secondary sex characteristics consistent
25 with their gender identity.

1 What are sex characteristics consistent with
2 their gender identity? And if you need to give an
3 example, feel free to give examples for children
4 based on what their sex assigned at birth would be.

5 MS. BROWN: Objection to form.

6 THE WITNESS: I'm happy to provide
7 examples from my understanding and then some of the
8 specifics may be more appropriate for a medical
9 provider, an endocrinologist, or a primary care
10 physician to address.

11 But, for example, a child who was
12 assigned male at birth and identifies as a female
13 and begins estrogen, for example, as an adolescent,
14 they may start to develop some breasts and develop
15 their chest that would be consistent with their
16 gender identity.

17 For individuals who are assigned female
18 at birth and have a transgender identity or identify
19 as male and in adolescence initiate a course of
20 testosterone treatments, they may develop
21 characteristics consistent with clitoral
22 enlargement, or facial hair, more body hair, things
23 like that.

24 BY MR. HILDABRAND:

25 Q. Thank you. Let's turn now to paragraph 24.

1 This is on page seven of your report.

2 A. Okay.

3 Q. And there you mention typically male names,
4 correct?

5 A. I see in the second sentence that there are
6 transgender boys who have typically male names. Is
7 that what you're referring to?

8 Q. Yes.

9 A. Okay.

10 Q. In your experience, do parents usually put a
11 lot of effort into choosing a child's name?

12 MS. BROWN: Objection to form.

13 THE WITNESS: Some parents may put
14 effort into choosing a name.

15 BY MR. HILDABRAND:

16 Q. And do some childrens' names carry deep
17 significance to a family?

18 MS. BROWN: Objection to form.

19 THE WITNESS: Do some parents use family
20 names for childrens' first names?

21 MS. BROWN: Same objection. And
22 objection as to relevance.

23 THE WITNESS: Some parents use
24 meaningful names or family names when assigning a
25 name to their child.

1 BY MR. HILDABRAND:

2 Q. What if a child expresses a transgender
3 identity and wishes to change a family name that
4 their parents gave them; what should a parent do if
5 the parent does not want to refer to their
6 transgender child by a new name?

7 MS. BROWN: Objection to form.

8 THE WITNESS: In that hypothetical
9 situation, it would be really important for the
10 individual and their family to collaborate with a
11 mental health provider. The research is very clear
12 that using an individual's chosen name and pronoun
13 is important and promotes their wellbeing in the
14 short and long term.

15 BY MR. HILDABRAND:

16 Q. Is it always harmful to use a transgender
17 child's pronouns that match their sex assigned at
18 birth rather than their preferred pronouns?

19 MS. BROWN: Objection to form.

20 THE WITNESS: Typically it is harmful
21 for an individual who has declared their gender
22 identity and their pronouns to continue to be
23 referred to by the pronouns of their sex assigned at
24 birth.

25 / /

1 BY MR. HILDABRAND:

2 Q. Was it harmful for parents to use pronouns
3 consistent with the child's sex assigned at birth a
4 year or two before the child expressed a transgender
5 identity?

6 MR. HILDABRAND: Objection to form.

7 THE WITNESS: Is the question about
8 whether it is appropriate for an individual to use
9 pronouns consistent with sex assigned at birth when
10 an individual has a cisgender identity consistent
11 with their sex assigned at birth?

12 BY MR. HILDABRAND:

13 Q. So my question would be, so say you have a
14 12-year-old who tells the parents that the child
15 is -- and we'll assume for this example that the
16 child was assigned a sex of female at birth and the
17 child tells the parents that the child is really a
18 boy.

19 At that point on, you would advise the
20 parents to use the male pronouns to refer to the
21 child if that's what the child prefers, correct?

22 MS. BROWN: Objection to form.

23 THE WITNESS: It is important to use an
24 individual's pronouns.

25 / /

1 BY MR. HILDABRAND:

2 Q. So it would be harmful to then call the
3 transgender boy by female pronouns; is that correct?

4 MS. BROWN: Same objection.

5 THE WITNESS: It is often harmful to use
6 incorrect pronouns or misgender an individual.

7 BY MR. HILDABRAND:

8 Q. Was it harmful two years before the child
9 expressed that the child was a transgender boy in
10 that example?

11 MS. BROWN: Same objection.

12 THE WITNESS: I'm not sure I understand.
13 So is it harmful when the child has a cisgender
14 identity?

15 BY MR. HILDABRAND:

16 Q. So would you agree in that hypothetical that
17 the child has a cisgender identity before expressing
18 a transgender identity?

19 A. You'd have to repeat all of the specifics for
20 me, I'm really sorry, in the hypothetical situation.
21 But when an individual identifies as cisgender, it
22 would be appropriate to use pronouns consistent with
23 their cisgender identity. When an individual
24 identifies as transgender, made a declaration about
25 their pronouns, it is appropriate and supportive of

1 their mental health to use those pronouns. Does
2 that -- sorry.

3 Q. I know it's hypothetical. Thank you for
4 answering it as best you could.

5 MR. HILDABRAND: I think this is a good
6 point for a break, if y'all would like to take a
7 short break.

8 MS. BROWN: Ms. Honeycutt, during the
9 break could you give us a time check if you have
10 time and can add up what you've been recording on
11 the record? I would really appreciate it. And,
12 yes, we would like to take a ten-minute break.
13 Thanks, Clark.

14 MR. HILDABRAND: Thanks.

15 (Recess observed.)

16 BY MR. HILDABRAND:

17 Q. Let's go back onto the record then. So in
18 paragraph 24, do you see where it says: For some
19 transgender adolescents, particularly those who have
20 changed schools after initiating medical transition,
21 their peers may not be aware that they are
22 transgender; is that correct?

23 A. Yes.

24 Q. So this concern is particularly troubling for
25 those who have changed schools after initiating

1 medical transition?

2 MS. BROWN: Objection to form.

3 THE WITNESS: I'm not sure what concern
4 you're speaking of.

5 BY MR. HILDABRAND:

6 Q. The concern expressed in paragraph 24 of your
7 report.

8 A. I'm going to need to review for context to be
9 clear in what concern we are talking about.

10 Q. That's fine. We can move on then. Is it
11 psychologically harmful to have separate teams for
12 boys and girls?

13 MS. BROWN: Objection to form.

14 THE WITNESS: What would be meant by
15 psychological harm?

16 BY MR. HILDABRAND:

17 Q. I believe you used the term "harm" in your
18 report. So as you understand in your report, would
19 it be harmful to have separate teams for boys and
20 girls?

21 MS. BROWN: Same objection.

22 THE WITNESS: It is not necessarily
23 harmful to have separate teams for girls and boys.

24 BY MR. HILDABRAND:

25 Q. Should teams be separated on the basis of

1 gender identity or on the basis of sex in your
2 opinion as a psychologist?

3 MS. BROWN: Objection to form.

4 THE WITNESS: I am not an expert in
5 designing team structure. I think the question is
6 whether an individual should participate on a team
7 based on their gender identity.

8 BY MR. HILDABRAND:

9 Q. Which team should nonbinary students play on
10 if their gender identity is neither male or female?

11 MS. BROWN: Objection to form.

12 THE WITNESS: It would be important to
13 collaborate closely with the nonbinary individual to
14 determine a course of action and plan that was most
15 appropriate to them in promoting their wellbeing.

16 BY MR. HILDABRAND:

17 Q. So we would ask the nonbinary individual
18 which team they would prefer to play on?

19 MS. BROWN: Objection to form.

20 THE WITNESS: We would collaborate with
21 the nonbinary individual to determine which team was
22 appropriate for them.

23 BY MR. HILDABRAND:

24 Q. Should transgender students participating in
25 athletic activities dress according to their sex or

1 according to their gender identity?

2 MS. BROWN: Objection to form.

3 THE WITNESS: It would be important for
4 many transgender individuals to dress and
5 participate in a manner consistent with their gender
6 identity.

7 BY MR. HILDABRAND:

8 Q. So if a transgender boy found it important to
9 the transgender boy's gender identity to dress like
10 a boy, should that transgender boy dress like a boy
11 while playing on boys' teams?

12 MS. BROWN: Objection to form.

13 THE WITNESS: It would be important for
14 a transgender male who has engaged in a social
15 transition to dress and appear in a manner
16 consistent with the gender identity, in this case
17 male.

18 BY MR. HILDABRAND:

19 Q. So if you had a 16-year-old transgender boy
20 who found it important to dress like a boy, who was
21 on a boys' swim team, should the transgender boy
22 wear a swimsuit -- a boy's swimsuit?

23 MS. BROWN: Objection to form.

24 THE WITNESS: In that hypothetical
25 scenario, I think it would be important to

1 collaborate with the individual about the uniform
2 and dress that would be comfortable and safe for
3 them to participate.

4 BY MR. HILDABRAND:

5 Q. If the individual insisted that -- if the
6 transgender boy insisted that the transgender boy
7 wanted to wear a boy's swimsuit, is that the correct
8 swimsuit for the boy to wear?

9 MR. HILDABRAND: Objection to form.

10 THE WITNESS: In my clinical experience,
11 I have not encountered that hypothetical scenario in
12 which an individual would only want to wear a male
13 swimsuit. It would be up to that individual to
14 determine what was appropriate for them.

15 BY MR. HILDABRAND:

16 Q. So we discussed earlier how most transgender
17 adolescents have not gone through surgery before
18 they turn 18; is that correct?

19 A. Correct.

20 Q. Would it psychologically harm a cisgender
21 girl to have to change in front of a transgender boy
22 who still has a penis?

23 MS. BROWN: Objection to form.

24 Irrelevant.

25 THE WITNESS: The question is about a

1 cisgender girl and locker room policies; is that
2 right? Can you repeat the question?

3 BY MR. HILDABRAND:

4 Q. Yes. Would it harm a cisgender girl to have
5 to change in front of a transgender girl who still
6 has a penis?

7 MS. BROWN: Same objection.

8 THE WITNESS: I think it would be
9 important to explore the risks and benefits. And
10 the important issue is around the individual with
11 their gender identity being permitted to participate
12 in activities in the full scope that's consistent
13 with their gender identity, and that would mean
14 developing an individualized plan for what that
15 would involve for that individual.

16 BY MR. HILDABRAND:

17 Q. So you cannot categorically say that it is
18 inappropriate for a transgender girl who still has a
19 penis to change in front of a cisgender girl; is
20 that correct?

21 MS. BROWN: Same objection.

22 BY MR. HILDABRAND:

23 Q. Yes or no, and then please answer further if
24 you need.

25 A. No. I think many cisgender and transgender

1 individuals are -- can be uncomfortable in locker
2 rooms. So if uncomfortable is a question of harm,
3 then we could delve into harm more specifically.

4 BY MR. HILDABRAND:

5 Q. So there might be some scenarios where it
6 would be harmful?

7 MS. BROWN: Same objection.

8 THE WITNESS: I am not aware of specific
9 harms in that scenario.

10 BY MR. HILDABRAND:

11 Q. Going to -- so in this section in your
12 report, the impact of SB 228 on transgender
13 students, from paragraphs 24 through 30, do you cite
14 only two studies? And feel free to scroll through
15 that to confirm.

16 A. You can scroll down. Keep scrolling. In
17 this section, I see two cited studies, and
18 additional information in the section was drafted
19 based on my professional and personal experience.

20 Q. Turning to paragraph 30 on page nine, do you
21 conclude by saying: By making it impossible for
22 many transgender students to participate in
23 interscholastic athletics, SB 228 denies transgender
24 youth the opportunity to engage in positive
25 experiences that can protect and enhance their

1 mental health? Is that what it says there?

2 A. Yes.

3 Q. Do you understand the law to make it
4 impossible for all transgender students to
5 participate in interscholastic athletics or only
6 many transgender students?

7 A. I would need to review the law again
8 specifically.

9 Q. Off the top of your head, you couldn't say if
10 it's all transgender students or many transgender
11 students?

12 MS. BROWN: Objection to form.

13 THE WITNESS: My impression is that the
14 law restricts all transgender youth from
15 participating in interscholastic athletics.

16 BY MR. HILDABRAND:

17 Q. Thank you. Are there other activities that
18 could provide, besides interscholastic athletics,
19 that students could participate at school to receive
20 similar mental health benefits?

21 MS. BROWN: Objection to form.

22 THE WITNESS: Within a school there are
23 many available extracurricular activities.
24 Athletics may be a very important part of someone's
25 experience and identity, however.

1 BY MR. HILDABRAND:

2 Q. Would it harm a cisgender girl if she did not
3 receive All State honors because a transgender girl
4 bumped her out of that position of earning All State
5 honors?

6 MS. BROWN: Objection to form,
7 relevance, and scope.

8 THE WITNESS: No, I don't believe that
9 would harm her.

10 BY MR. HILDABRAND:

11 Q. Would it harm a natal girl or a cisgender
12 girl if a transgender girl beat her and every other
13 cisgender girl in the competition?

14 MS. BROWN: Same three objections.

15 THE WITNESS: No, I do not believe
16 that's a circumstance of harm.

17 BY MR. HILDABRAND:

18 Q. Would it harm a cisgender girl if she were
19 injured playing girls' basketball against a
20 transgender girl?

21 MS. BROWN: Object to the form.

22 THE WITNESS: Risk of injury is present
23 in participating in sports for people regardless of
24 their gender identity.

25 / /

1 BY MR. HILDABRAND:

2 Q. So yes or no? Do you view that as a harm?

3 MS. BROWN: Objection to form.

4 THE WITNESS: In what manner?

5 BY MR. HILDABRAND:

6 Q. Is it a harm for a cisgender girl to be
7 injured playing girls' basketball against a
8 transgender girl?

9 MS. BROWN: Same objection.

10 BY MR. HILDABRAND:

11 Q. Or is that simply a risk that comes with
12 playing basketball?

13 A. I think that's a risk that comes with playing
14 basketball.

15 Q. Let's turn ahead to -- you cite your current
16 WPATH Standards of Care and we discussed those
17 today, correct?

18 A. Correct.

19 Q. To the best of your understanding, do the
20 current standards of care take a position on whether
21 social transition is appropriate for prepubertal
22 children?

23 A. The standards of care is a lengthy document.
24 And from my recollection, I believe they address
25 complexities and nuances in making decisions about

1 treatment planning, including a social transition.

2 MR. HILDABRAND: Opposing counsel, when
3 is the end time that you have?

4 MS. BROWN: We're at 12 minutes and 36
5 seconds. Ten minutes.

6 MR. HILDABRAND: Ten minutes, okay. All
7 right. Travis, can you circulate Doc R.

8 THE WITNESS: Do you think we can open
9 that? Yes.

10 MR. HILDABRAND: And we are going to
11 mark this as Exhibit 15.

12 (WHEREUPON, a document was marked as
13 Exhibit Number 15.)

14 BY MR. HILDABRAND:

15 Q. Does this appear to be the seventh edition of
16 the standards of care?

17 A. It does.

18 Q. Is that the current version of the standards
19 of care?

20 A. It is. Standards of care eight is in
21 development and hope to be released soon.

22 Q. When it's released, will you begin to
23 consider version eight once it's released and use
24 that in your practice?

25 A. I will review standards of care eight when

1 it's released.

2 Q. Let's turn for this to I think it's page 17
3 in the standards of care's page numbering but it's
4 page 23 of the PDF. It's the page that says:
5 Social transition in early childhood.

6 A. Okay. 23, we're there.

7 Q. Can you read the first paragraph, starting at
8 the line -- let's see. Just one second. Do you see
9 where it says: Social transitions in early
10 childhood do occur within some families with early
11 success? This is a controversial issue and
12 divergent views are held by health professionals.
13 The current evidence base is insufficient to predict
14 the long-term outcomes of competing a gender role
15 transition during early childhood. Outcomes
16 research with children who completed early social
17 transition would greatly inform future clinical
18 recommendations. Do you agree or disagree with
19 these sentences, and are there any parts of it that
20 you would change?

21 A. I agree a social transition is a complex
22 issue and is often navigated with success.

23 Q. All right. Are you aware of any new chapters
24 that will be added to the WPATH Standards of Care in
25 version eight?

1 A. My impression is that the standards of care
2 eight will include informed updates around the
3 treatment of nonbinary and gender-diverse
4 individuals. They may also include some updates in
5 mental health considerations for children as well.

6 MR. HILDABRAND: Travis, can you
7 circulate doc -- actually, no.

8 BY MR. HILDABRAND:

9 Q. Are you aware that there is a draft chapter
10 on eunuchs in version eight?

11 MS. BROWN: Objection to form.

12 THE WITNESS: I was not aware of that.

13 BY MR. HILDABRAND:

14 Q. All right. Do you view eunuchism as a gender
15 identity?

16 MS. BROWN: Objection to form.

17 THE WITNESS: I am not aware of anyone
18 with the identity eunuchism.

19 BY MR. HILDABRAND:

20 Q. If WPATH published a standard of care chapter
21 on eunuchism and said that eunuchism is a gender
22 identity, would that be something that you would
23 follow in your practice?

24 MS. BROWN: Objection to form.

25 THE WITNESS: I would need to review the

1 standards of care and make a decision about how that
2 would influence my practice.

3 BY MR. HILDABRAND:

4 Q. While you're not a pediatrician or an
5 endocrinologist, are you aware that the FDA recently
6 placed additional warnings on the use of puberty
7 blockers?

8 A. I was not aware.

9 MR. HILDABRAND: Travis, can you
10 circulate Doc W. And we'll enter this as
11 Exhibit 16.

12 (WHEREUPON, a document was marked as
13 Exhibit Number 16.)

14 BY MR. HILDABRAND:

15 Q. Is this titled, Risk of Pseudotumor Therapy
16 Added to Labeling for Gonadotrophin-Releasing
17 Hormone Agonists? Is that the title of the
18 document?

19 A. Yes.

20 Q. And does it say from the Food and Drug
21 Administration?

22 A. I see that, yes.

23 Q. Would you consider FDA warnings if you were
24 aware that one of your patients were on puberty
25 blockers?

1 MS. BROWN: Objection to form and scope.

2 THE WITNESS: I am not a prescriber and
3 so do not follow closely FDA warnings.

4 BY MR. HILDABRAND:

5 Q. So you have not advised any patients about
6 any new FDA warnings about puberty blockers; is that
7 correct?

8 MS. BROWN: Same objection.

9 THE WITNESS: I am not aware of these
10 until this exhibit was presented.

11 BY MR. HILDABRAND:

12 Q. Are you aware that the United Kingdom's
13 National Health Service recently closed the
14 Tavistock Gender Identity Disorder Clinic?

15 MS. BROWN: Same objection and objection
16 to relevance.

17 THE WITNESS: Yes, I'm aware.

18 BY MR. HILDABRAND:

19 Q. What is your understanding of why it was
20 closed?

21 MS. BROWN: Same objection.

22 THE WITNESS: My impression is that
23 clinics have been closing due to significant
24 backlash and discrimination against providers and an
25 inability to provide care for the patients that they

1 serve.

2 BY MR. HILDABRAND:

3 Q. Given that clinics such as Tavistock have
4 been closing recently, does that give you any
5 concern or doubt about your current approach to the
6 practice of psychology?

7 MS. BROWN: Same objection.

8 THE WITNESS: I continue to practice in
9 a way that is consistent with best practice
10 guidelines and the guidelines we've discussed today.
11 Any concern in my practice would be related to fear
12 of response in the community and harassment from
13 others who are not affirming of a transgender or
14 gender-diverse identity.

15 BY MR. HILDABRAND:

16 Q. Are there generally many more individuals
17 identifying as transgender or nonbinary in the past
18 few years than there were, say, ten years ago in
19 your experience?

20 MS. BROWN: Objection to form.

21 THE WITNESS: In the past ten years,
22 more individuals have come forward as identifying as
23 gender diverse or transgender and this is true of
24 many psychological conditions as well, that our
25 prevalence rates have increased for depression and

1 autism spectrum disorder and other conditions as
2 well.

3 BY MR. HILDABRAND:

4 Q. Just to wrap up, have you understood the
5 questions that I have asked today and answered to
6 the best of your ability?

7 A. Yes, I have or sought clarification when
8 needed. Thank you.

9 MR. HILDABRAND: Of course. Thank you.
10 That is all that I have. Thank y'all for going
11 through this. Does Jessica, I guess, do you have
12 any questions?

13 MS. JERNIGAN-JOHNSON: I do not. Thank
14 you.

15 MS. BROWN: Okay. If you could give
16 us --

17 MR. HILDABRAND: If you need a few
18 minutes before coming back, that's fine with me.

19 MS. BROWN: No. We don't have any
20 redirect or questions for this witness.

21 THE REPORTER: Mr. Hildabrand, would you
22 like to order this transcribed?

23 MR. HILDABRAND: Yes. Thank you.

24 THE REPORTER: Ms. Brown, would you like
25 to order a copy?

1 MS. BROWN: Yes, we would.

2 MR. HILDABRAND: Before we wrap up, did
3 we enter the FDA risk article as an exhibit?

4 THE REPORTER: Document W, Exhibit 16,
5 yes, sir.

6 MR. HILDABRAND: We did, okay. Great.
7 Just wanted to make sure. All right.

8 MS. BROWN: And, Ms. Honeycutt, we'll
9 read and sign instead of waiving.

10 FURTHER DEPONENT SAITH NOT
11 (Proceedings concluded at 5:57 p.m.)

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E R R A T A P A G E

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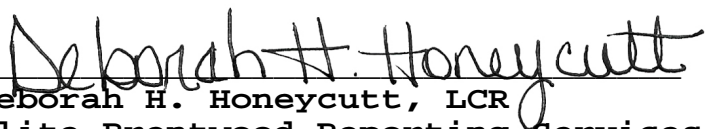
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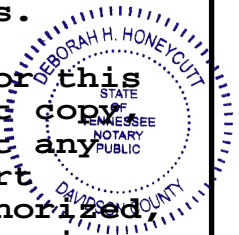
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